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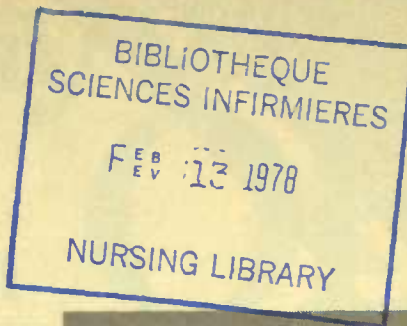
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The Canadian Nurse

JANUARY 1978

The official journal of the Canadian Nurses Association published monthly in French and English editions.

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Our cover photo, "The Mystery of Death," is the work of one of the pioneers of 19th century photography, Charles Nègre who was born in the south of France in 1820 and died in 1880. His work was the subject of a major exhibition at the National Gallery of Canada in 1976. Permission to reproduce "The Mystery of Death" (after a medallion by August Préault) November, 1858, was given by the National Gallery of Canada, Ottawa.

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses Association.

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Perspective

Herein

The basic purpose of nurses' unions is to improve the salaries and working conditions of the nurses who belong to them. In the early '60s, many professional nursing associations were instrumental in organizing nurses for collective bargaining with a view to becoming the certified bargaining agent for nurses. A great deal of money and energy was expended to achieve this objective.

Today, with the exception of British Columbia, nurses' unions in the provinces are separate, independent organizations. They are not linked in any way to the professional nurses' associations. This came about largely because Labour Relations Boards questioned the fact that professional association membership included management nurses. Management nurses were not eligible to join the union because the labor laws exclude them from union membership.

Most nurses are members of their professional association and their union. On examination, it becomes evident that the functions of the two organizations are distinct and separate.

Although these roles do not seem to overlap or conflict with one another, problems continue to arise between the memberships of both organizations because of the nature of their functions.

The efforts of the union are visible to the nurse. It is easy to see the benefits of collective bargaining because these benefits have a direct bearing on a nurse's working environment and living conditions. They also provide job security and recourse to the solution of problems that may occur in the work situation. The money a nurse pays to the union each month has distinctly visible results.

The professional nurses' association, on the other hand, plays a very important role in the development of standards of nursing practice, but often the nurse does not understand or appreciate the value of services she receives from her professional organization. This places a responsibility on the professional association to capture the nurse's interest and get her involved. As a member of the association the nurse also has a responsibility to promote the standards established by her profession.

And so the nurse must wear "two hats," one as a member of her professional association and a second as an employee and member of a union. Sometimes, she has to wear both hats at the same time. This can be confusing and create misunderstanding.

Both the union and the professional association have a responsibility to educate their members. There is a very real need for a channel of communication between both groups; otherwise there will be conflicts.

Important decisions which affect one group should be communicated to the other. This will avoid conflicting statements which give the public the impression that the nursing profession is divided against itself.

Some of the Labour Relations Acts give nurses the right to strike, and from time to time nurses have taken advantage of this right. Strike action can cause a long-lasting split between the two organizations

unless there is understanding and support from both groups. A program of public relations should be planned prior to the strike if the unity of the profession is to be preserved.

The professional associations under the provincial nurses' acts have the right to suspend or cancel registration for reasons outlined in the various acts. The union on the other hand has the right to go to grievance arbitration if a member is suspended or dismissed. If the employer does not prove his case the nurse will be reinstated. The situation becomes more complicated if the professional association removes her from the register for unsafe practice. This can constitute another area of conflict.

The professional association and the union function under two separate pieces of legislation. By law they must remain separate independent organizations, functioning without interference from one another, but this does not prevent them from working together on common goals or from communicating with each other on programs or decisions that affect both groups. They can, in fact, *they must* begin to work together towards this end.

— Glenna Rowsell, Director of Labor Relations, Canadian Nurses Association.

This month's new cover design is just one of the surprises in store for CNJ readers in 1978. When our six-member editorial advisory committee met with editors of *CNJ* and *L'infirmière* in Ottawa early in December, the group came up with lots of ideas for an easier to read and more exciting journal. So, keep your eyes open.

Next month, watch for "Here's How," a monthly column featuring ideas from you, the reader, on how to make life a little easier as you work your way through another shift. If you have an original and practical suggestion that you think might help other nurses to improve any aspect of patient care, why not share your idea with other readers? What's more, you'll be money ahead, because *CNJ* will pay \$10 for any suggestion published. So let's hear from you.

Too many parents today say that they are "in the dark" as far as **infant feeding** is concerned. Left to their own resources, they are faced with any number of convincing but not necessarily sound arguments about what to feed their new baby. This month, author Carol Sage tells us why it is so important for us to provide sound infant nutrition education, and Deborah Chute lets us know how we can make the most of our teaching opportunities with new parents.

Until recently, **systemic lupus erythematosus** has been considered a rare and terminal illness. Now it is recognized that the disease is neither uncommon nor inevitably fatal. **Next month** Bonnie Hartley helps clear up some common misconceptions about the disease, takes a good look at how lupus patients themselves perceive their disease, and focuses on the most important aspects of our patient teaching.

And speaking of patient teaching — how much does your patient know about his **cortisone therapy**? Does he know what it does for him ... what side effects he should report to his doctor? In addition to an article for nurses, Bonnie Hartley has written an article for patients — an instructional package designed to help them understand cortisone.



The major role of the professional association lies in the improvement of practice through standards of selection, preparation and performance of practitioners, as well as setting standards for nursing practice.

The union on the other hand, exists to regulate relationships between the employer and employees with a view to improving the working conditions and salaries of its members.

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Input

An uncharted area

I would like to draw to the attention of nurses an unnecessary and illogical development that is occurring in our Health Care System, i.e. the setting up of emergency medical or paramedic services.

We are in neither a wartime situation nor a critical shortage of nurses. Why is it that registered nurses are allowing paramedical personnel to undertake nursing activities or emergency activities?

There is no valid reason this particular field has not been entered by nurses; the nurses are asked to care for the victims; not to fetch them. No matter how good the paramedical course is nor how many hours of instruction are given, nurses are still in a better position to provide quality care, and they have the appropriate background to start with and build upon.

In addition to the above, are even more practical considerations: it's an interesting, challenging field, the nurse is working to her full potential, and it will remove a number of nurses from the ranks of the unemployed.

— Nicole Legaré, Ottawa, Ontario.

Seasonal shortage

In the introduction to Katherine Zin's article "A Canadian Grad Goes to the States" (October, 1977) she says "She found a job in Florida — a state which is always short of nurses since it has only one school of nursing and a total of 22 hospitals." This statement is rather misleading.

There definitely is a shortage of nurses in certain areas of Florida, especially during the winter season. There are many reasons for the shortage, but a lack of schools of nursing is not a major factor. We do have only one hospital school of nursing in Florida, but in addition we have several associate degree nursing programs located in the community colleges and a few undergraduate nursing programs in the senior universities.

Also, there are over 50 hospitals in the Miami area alone.

Katherine's article is well written and it is to be hoped her homesickness is not too acute.

— Joan R. Vogel, R.N., B.S., M.S.N., National Director of Nursing Services, Medical Personnel Pool, Ft. Lauderdale, Fla.

Surgical gloves

I have written this letter to help familiarize nurses with a product that, in many cases is taken for granted — surgical gloves. Twenty million pairs of surgeons' gloves are used annually in Canada and all sorts of post-operative complications can be directly attributed to glove defects, powder, or sterile techniques and glove packaging.

One of the greatest dangers in this area is the minute pinholes that are created during the glove manufacturing process. Many such pinholes go unnoticed at the plant, even though gloves are said to be inspected. As a result, defective gloves are sent to hospitals as a finished product and once they are donned by a surgeon or nurse, the pinholes become even more difficult to see. These pinholes are often found between fingers or at the end of thin fingertips, acting as a drain allowing the surgeon's perspiration to flow into the surgical site.

Most of these pinholes are so small that they go completely unnoticed during a quick visual inspection by the surgeon in the O.R. Pinholes are often hidden by powder, once wet, will not contrast the color of the hand, camouflaging the pinhole and the dangers that accompany it.

To ensure that your O.R.'s are using the safest brand, ask the manufacturer about the methods used to inspect gloves.

You should be aware of those who statistically inspect a given number of gloves and assume that all the others are safe and free of pinholes. Look for the manufacturer who does a 100% inspection of each glove and air inflates each glove to five times its normal size, against high intensity light banks, using a magnification lens to visually search out and destroy all products that are potentially dangerous to a patient.

Some manufacturers do use such methods of inspection and offer products that although identical to other brands, based on a one-to-one comparison, clearly offer a higher degree of safety to the patient.

— J.P. Lachance, representative of a surgical glove manufacturer, Beaconsfield, Quebec.

Call for help

We have recently added an Extended Care Unit to our hospital; following that, we had a flood in our library; then the library was moved to another area. Some time during these upheavals, a number of copies of our *American Journal of Nursing* disappeared. I wonder if your readers could assist in replenishing our collection?

The missing issues are as follows:

1975: March, May, August, October, November.

1976: February, April, May, June, July, August, October, November, December.

1977: January, February.

Your assistance is kindly appreciated.

— Rosemaree Gentles, Education Coordinator, Mount Saint Joseph Hospital, Missionary Sisters of the Immaculate Conception, 3080 Prince Edward St., Vancouver, B.C. V5T 3N4.

She, shis and shim

Thank you Ella MacLeod (September, 1977) for taking the trouble to help turn the tide from the ridiculous lengths to which our language has been taken! Unfortunately the result of such deformation of chairman and other "man words," has only weakened the just cause of competent women whose need for equal opportunity and remuneration remains unmet.

— Nancy Garrett, professor, Université du Québec, Hull, P.Q.

Did you know ...

All graduates of the Halifax Infirmary are asked to send in their name, class and current mailing address to the Infirmary Alumnae in preparation for the 1978 celebration of the 60th anniversary of the school. Contact: Halifax Infirmary Alumnae, Box 12, Gerard Hall, Morris St., Halifax, N.S., B3J 2H6.

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Clinical Wordsearch

Answers

Puzzle no. 10 (appears on page 19)

- | | |
|---------------|---------------------|
| 1 Sight | 20 Sclera |
| 2 Strabismus | 21 Eye |
| 3 Glaucoma | 22 Sty |
| 4 Blind | 23 Conjunctivitis |
| 5 Nystagmus | 24 Optic Nerve |
| 6 Aqueous | 25 Orbit |
| 7 Microscopic | 26 Lacrimal Gland |
| 8 Myopia | 27 Ophthalmoscope |
| 9 Astigmatism | 28 Epicanthal |
| 10 Cornea | 29 Scleral Ulcer |
| 11 Lens | 30 Iridotomy |
| 12 Diplopia | 31 Oculist |
| 13 Cilium | 32 Glasses |
| 14 Pupil | 33 Magnify |
| 15 Iris | 34 Focus |
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| 19 Lid | 38 Pin |

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News

Nurse researchers attend workshop on research methodology

Nursing research in Canada has come a long way in the past five or six years and now stands on the brink of a limitless future IF nurse researchers in this country can continue to narrow the gap between research and practice. To do this, they are going to have to look at ways of:

- devising investigatory methods and instruments peculiar to nursing, not simply borrowing those of various other disciplines;
- focusing on an approach that is still closer to reality;
- providing incentives for patient participation;
- avoiding counter-productive individualism;
- breaking down the barriers that are created by jargon and abstractions.

These were some of the conclusions reached by more than 100 Canadian nurse researchers who attended the recent Workshop on Research Methodology in Nursing Care sponsored by the Canadian Nurses Association in cooperation with the University of Ottawa school of nursing. The three-day invitational meeting took place on the University of Ottawa campus on November 9, 10 and 11.

Workshop organizers identified the objective of the meeting as an attempt to provide a representational group of nurse researchers from all across Canada with the opportunity to:

- identify methodological problems
- share solutions to these problems
- develop participants' skills in dealing with these problems
- reinforce the commitment of nurses to engage in research.

Both beginning and experienced researchers, along with nurses who have a critical interest in nursing research, were invited to participate in the workshop. Partial funding for the workshop as a project intended to facilitate the development of health care research and improve its quality, rather than to serve as a forum for the sharing of existing information, was received from the federal government's National Health Research and Development Program. Funding was also received from the Department of the Secretary of State.

Workshop format

A total of eleven papers were presented during the three days of the workshop. Each speaker described methodological problems encountered in the course of current or



A seven-member planning committee was in charge of preparations leading up to the Workshop on Research Methodology in Nursing Care. Here, six members of the committee are pictured during a break from the proceedings (left to right): Louise Lévesque, Université de Montréal; Marion Kerr, Canadian Nurses Association; Pamela Poole, planning committee; Marie Loyer, University of Ottawa; Helen K. Mussallem, Canadian Nurses Association; Vivian Geeza, workshop coordinator. CNA president Joan Gilchrist was not present for this picture.



Four nurse researchers who participated in the recent workshop take time for a coffee break between sessions held in the University of Ottawa Unicentre.



projected research projects — projects that ranged from "Studying Nurse Influence on the Quality of Life of Elderly Patients with Chronic Illness" to "Studying the Development of Health Behavior in Children."

Two discussants responded to the problems described by each of the eleven researchers, presenting suggestions as to how these problems might be or might have been solved and assessing the merits of the project. A general discussion period at the end of each presentation allowed for audience participation.

Commenting on the workshop format at the conclusion of the conference, Louise Lévesque, a member of the Planning Committee, said: "I want to congratulate all the participants on the remarkable spirit of friendship, open-mindedness and cooperation which prevailed throughout the workshop. It must be emphasized that the authors of these research papers did not try to impose their arguments as the 'final word' but, rather, shared their doubts as well as convictions with the other participants, and the discussants offered constructive criticism, thus avoiding the pitfall of ready-made recipes.

"The gatherings, both formal and informal, allowed participants to further their knowledge, and to question or reinforce some of their own convictions. Quite often, opinions expressed by resource persons were conflicting, but differences were respected. With tact, humor and a common aim of objectivity, the group always managed to bridge the gap between divergent viewpoints and to enhance the constructive nature of the comments that were offered."

Program

Participants were welcomed on the opening day of the workshop by Marie A. Loyer, dean of the University of Ottawa school of nursing, who observed that "the cradle of bilingualism in Ontario" was a fitting site for a conference that would demonstrate increasing interest among French-speaking nurses in nursing research.

Some 20 French-speaking nurse researchers participated in the event for which simultaneous translation was provided. Workshop proceedings, which will be available in the new year, will be published in both English and French.

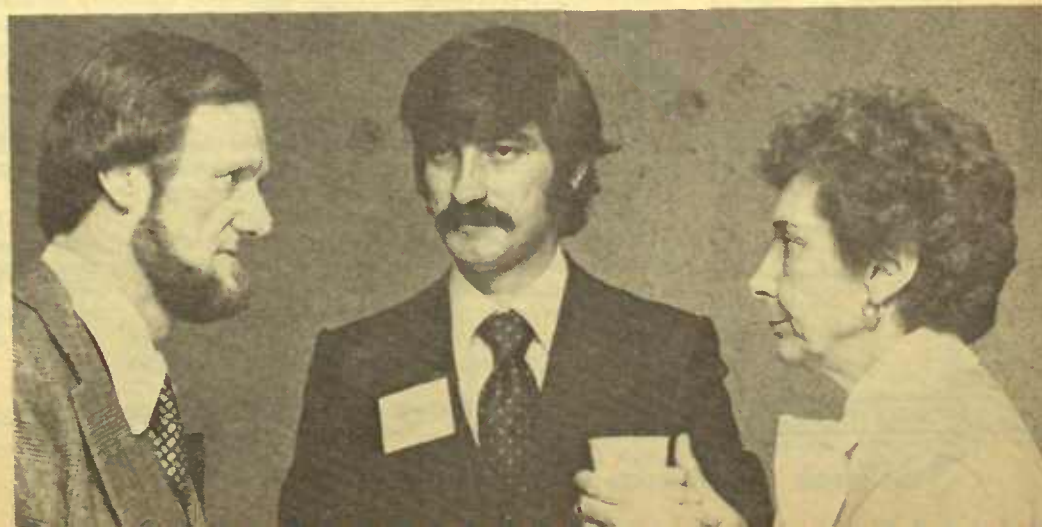
CNA president Joan Gilchrist also welcomed participants to the workshop and pointed out that "researchers need some kind of forum in order to acquire a national perspective and work together to develop nursing research." She reminded participants that the meeting was the fifth national ►



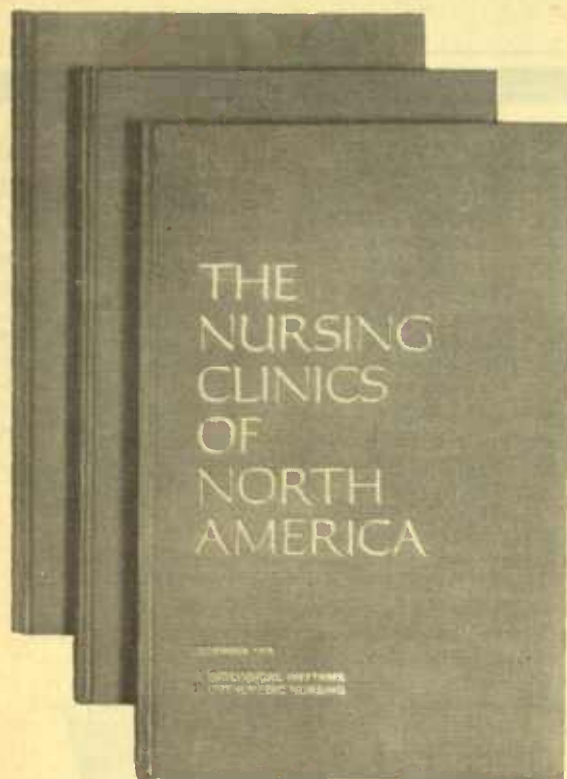
Time out for questions from the audience. Panel members during one of the morning sessions consisted of (left to right): moderator, Serge Trachy, Montréal; discussant, Janet Kerr, University of Calgary; presenter, Mary Gibbon, Victorian Order of Nurses, Hamilton-Dundas Branch; discussant, Judith Ritchie, University of New Brunswick.



Coffee break finds Eric Parrott of CNA Testing Service (left) and Helen Glass, of the University of Manitoba talking with Serge Trachy of Hôpital Maisonneuve - Rosemont, Montréal.



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News

CNA president addresses ONQ annual meeting

The president of the Canadian Nurses Association, Joan Gilchrist, has issued an appeal to the 49,500 nurses who live in the province of Québec to support their national association by active participation and collaboration in the definition of both present and future needs of organized nursing. "The human element is obviously crucial for the survival of our professional organization," the CNA president said in her recent address to members of the Order of Nurses of Québec during their two-day annual meeting in Québec City. She reminded her audience of 900 nurses that more than one-third of CNA's 115,000 members live in the province of Québec and expressed the view that nursing associations must find improved channels for "tuning in" to their membership.

"It seems obvious to me that professional organizations will continue to serve their members and society, on the express condition that they tackle those problems that their members cannot resolve individually," Gilchrist observed.

Report of the executive director

Executive director and secretary of the Order, Nicole du Mouchel reported that at the end of December, 1976, ONQ membership stood at 49,567, approximately 87 percent of whom were employed in nursing. She reported that during the past year the Order had taken action in the following areas:

- study and adoption of regulations concerning the professional inspection committee's procedure;
- adoption of draft regulations for the establishment of a joint committee on nursing education;
- comments and recommendations on stipulations concerning the working knowledge of French required to obtain a practicing permit from the professional bodies;
- approval of a draft regulation concerning acts which may be performed by persons who do not belong to the nursing profession (Section 36 of the Nurses' Act).

Several reports were published during the year on the following topics: nursing in prolonged care; a study of material for mental health nursing (the final document is being completed) and a report on the role of the nurse in the field of addiction. Another on nursing practice in Local Community Health and Social Services Centers (CLSC's) is in preparation. The provincial bulletin, *Nursing-Québec*, and a new 24-hour telephone answering (free) service with a tape recorded message that is changed at regular intervals now provide continuous information throughout the province.

The financial picture

For the fiscal year ended March 31, 1976, the ONQ registered a modest revenue increase over the preceding year. However, expenditures were much higher than in previous years and the deficit for the fiscal year reached \$553,956 (compared to an anticipated deficit of \$301,283). Reasons included adoption of a new organizational structure for the Order resulting in additional expenditures for general administration, staff recruitment, salaries and fringe benefits. Expenditures incurred in remodeling the ONQ headquarters also entered into the picture.

In the light of this deficit, the Bureau will undertake to curtail expenses and is contemplating a membership fee increase for 1979-1980.

Nursing acts

A lively discussion on authorization of nursing and medical acts, introduced by ONQ vice-president Raymond Boulay, proved to be one of the highlights of the meeting. Speakers covered a variety of topics ranging from definitions of authorized and restricted acts, standing prescriptions, and implementation of care techniques, to medical acts which may be performed by nurses under supervision and nursing acts which may be delegated to auxiliary nurses.

It was clear from the discussion that participants agreed, on the one hand, that nursing was not medicine, and, on the other hand, that they did not believe than an exclusive profession such as nursing could allow nursing assistants to perform the same acts and be included in the same professional definition.

Lawyer André Desgagné, president of the Office des Professions, who was present for the discussion, commented that setting up dividing lines is a delicate matter since real life situations do not closely resemble legal definitions. He emphasized that it was possible to envisage that "some acts could be performed in harmony by either category" and concluded with the hope that any serious problems that remained could be settled painlessly as soon as possible.

The Administrative Committee

Members of the newly elected Administrative Committee are: Jeannine Tellier-Cormier, president (until November 1978); Raymond Boulay, vice-president; Andrée Paulet, treasurer; Guy-Anne Garceau, director; Jeannine Pelland-Baudry, director; and Jean-Paul LaRue, director and representative of the public appointed by the Office des Professions du Québec.

Other business

The meeting also reviewed activities of various nursing committees, including Pedagogical Appraisal, Nursing Education, Continuing Professional Education, Scholarships, Motions, Permits, Discipline and the Committee of Examiners.

A total of 18 resolutions were received from the floor, not including amendments; in addition, 30 other resolutions were referred to the Bureau when time ran out.

CNA MEMBERS AND ASSOCIATION MEMBERS

CNA members and association members are invited to submit resolutions for presentation at the Annual Meeting and Convention, June 1978.

Resolutions must be signed by a CNA member and forwarded to the Resolutions Committee, CNA House by 31 March 1978.

Resolutions received after 31 March 1978 cannot be presented to the annual meeting.

Stress institute plans symposium

A symposium on stress, cancer and death involving 20 specialists on different aspects of this topic will be one of the outcomes of a federal contribution to the International Institute of Stress in Montreal. The \$150,000 grant to the non-profit institute directed by celebrated scientist-philosopher Hans Selye, was announced recently by Health and Welfare Minister Monique Bégin.

The institute will also offer a series of workshops on living under stress, to be presented in various cities across Canada, as well as international conferences dealing with a variety of stress-related topics.

The International Institute of Stress seeks to promote research on the mechanisms of stress and stress-induced disease. Through international discussion and education on the problems of stress in modern society, founders of the institute hope to develop methods of coping with stress. Their inter-disciplinary approach will include research on the stressor effects of accelerated urbanization, the design and use of public buildings for maximum health benefits and the creation and evaluation of stress tests.

Organizers of the Canadian Stress Institute are Toronto consultants Adam and Edita Kowalski, who are working with the support of Hans Selye. Adam is also

a lecturer at Durham College of Applied Arts and Technology in Oshawa, Ontario, and Edita, a former teacher and editor in the educational field, is a freelance writer.

Health happenings

The first U.S. center for research in cancer nursing will be established at the Memorial Sloan-Kettering Cancer Center in New York City through a research development grant. The primary objectives of the three-year grant are to study ways to improve the nursing care of cancer patients and to forge closer links between the growing field of nursing research and the vast numbers of nurses who are responsible for the daily care of patients with cancer.

Chinese patients in downtown Toronto's Mount Sinai Hospital are being brought **Chinese meals** as part of the hospital's effort to cater to the needs of members of an ethnic community. The meals, provided daily through a Chinese meals-on-wheels program, allows patients to choose from a menu of 12 Chinese dishes. According to Maria Lee, co-ordinator of the hospital's Chinese services, the meal service helps to increase the patients' feeling of general well-being by providing him with the food he is accustomed to. At present, Mount Sinai is the only Toronto hospital providing this service, but Lee would like to see it extended to nursing homes and chronic care hospitals.



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News

Smallpox eradication "a very small beginning"

A decade has passed since the World Health Organization launched its ten-year campaign against smallpox. Dr. Donald A. Henderson, dean of Johns Hopkins University and formerly chief of WHO's Smallpox Eradication Unit, told the exciting saga of smallpox eradication at a November meeting on infectious diseases.

It is now estimated that in 1967, when the program began, there were 10 to 15 million cases of smallpox in the world, and that the disease was endemic in 33 countries. These countries included those south of the Sahara in Africa, Afghanistan, India, Indonesia, Nepal, Pakistan, and Brazil.

Henderson said that when WHO decided on the ten-year program, few believed that it was a practical possibility. Now, he says, it can be believed that the last case of smallpox will be eradicated by December 31, 1977.

Why smallpox? Henderson talked about the preeminence of smallpox as "the most devastating disease in history." He also said that it was a disease that could be tackled with some success because man is its only reservoir. Transmitted solely by face-to-face contact, smallpox appears in clusters or population groups. It is a disease that cannot be transmitted by asymptomatic carriers. The vaccine for smallpox is excellent with an efficacy rate of 90% at twenty years.

Smallpox is a viral disease, characterized by fever, and aching pains, followed by a vesicular-papular rash that results in characteristic pitting scars and often blindness. There is no successful treatment for the disease.

The problems confronting WHO in January 1967 were monumental. The program required the cooperation of 50 countries to be a success. It also required a number of strategies that would be specific to each country and each community involved. WHO needed large amounts of vaccine, an effective way to administer the vaccine, and a

reliable method of surveillance (reporting of cases) and containment.

Vaccine was originally donated. Standards had to be developed to ensure the quality of the vaccine; it was then produced in the developing countries themselves; these countries in turn, donated it to other countries.

Methods of injection had to be considered. Eventually, a simple bifurcated needle was chosen as the easiest, and most economical method of injection.

Once these problems were solved, the task could be begun. It was accomplished by using the resources and people of each country. Effective reward systems had to be put into operation to ensure that vaccination and surveillance would be accurate and complete.

Henderson also told his audience of the individual approaches used in different communities, their setbacks and finally, successes. Surveillance and containment were not attained without difficulty — he said that it took some time to develop an effective system for accurate assessment of the number of cases of smallpox in a given area.

At the time of his address, Henderson believed that smallpox had been eradicated in all countries with the exception of Somalia where there remained a handful of cases. He expressed confidence that by the end of the year, eradication would be complete.

In closing, Henderson said that the success of the program was "a very small beginning ... to the prevention of disease as its source, rather than the provision of sickness care."

Dr. Henderson told his story as guest speaker at the Conjoint Meeting of Infectious Diseases, sponsored by the Laboratory Division and the Tropical Medicine and International Health Division of the Canadian Public Health Association in Ottawa in late November.

Occupational health nurses in Alberta organize

The Alberta Occupational Health Nurses Association, a special interest group of the AARN, elected its first slate of officers and held an organizational meeting of the new executive.

Officers for the coming year, elected by postal ballot, are: Ruby Meunier, Red Deer, president; Marg Muza, Red Deer, vice-president; Lillian Scott, Edmonton, secretary; Beth Sadler, Calgary, treasurer. Zone representatives are: Jean Eilers, Grande Prairie; Dorothy Smith, Edmonton; Carol Kraft, Red Deer; Marg Olsen, Calgary; and Wilma Ratcliff, Medicine Hat.

The constitution and bylaws of the new association were approved at a meeting last Spring held in conjunction with the AARN annual meeting in Calgary.

Ontario chronic home care project enters phase II

The results of a recent Ontario government report indicate that home care for chronically ill patients is more economical than institutional care on a per-patient basis and that home care eases or prevents the further physical and mental deterioration of those it serves.

The Report on the Evaluation of Chronic Home Care summarized the findings of the Chronic Home Care Project begun in 1975 and made recommendations for action concerning Phase II of the evaluation of chronic home care.

Dennis Timbrell, Ontario's Minister of Health explained that the history of home care in Ontario began under the Toronto Board of Health in 1958, under the Victorian Order of Nurses in Ottawa in 1964, Guelph in 1965 and in Hamilton, London and Windsor in 1966. Its original purpose was to reduce the demand for active treatment beds.

Guidelines developed in 1970 and refined in 1973 restricted home care to short-term active care where rehabilitation was a realistic goal. In 1975 however, it was proposed that extending home care into the chronic care sector be examined.

In response to this proposal, home care programs were extended into the chronic care sector in Kingston, Thunder Bay and Hamilton with the understanding that these programs would be evaluated to determine their value and cost-effectiveness.

Timbrell stated that because of the very significant cost of the program, the Ontario government is not prepared at present, to expand the chronic home care programs throughout the province until the potential cost and ultimate effect of the program on the rest of the health care system is examined.

- The Report recommends that:
- the chronic home care program continue for another 18 months as it presently exists in Hamilton, Kingston and Thunder Bay;
 - a more extensive evaluation now feasible due to stabilizing case load, be carried out on the chronic home care programs for a 12-month period (allowing four months to prepare for the study and two months to prepare a report);
 - the home care information system be revised to provide patient-specific data and indicators of health status.

Health happenings in the news

Malnutrition and infectious diseases must be regarded as the world's most menacing health problems, states Erik Eckholm, a researcher at the non-profit Worldwatch Institute in Washington, D.C. Having recently completed a book, *The Picture of Health*, for the UN Environment Program, Eckholm said that undernutrition will bow only to economic reforms where governments invest heavily in water supply and waste disposal facilities and where personal cleanliness becomes routine.



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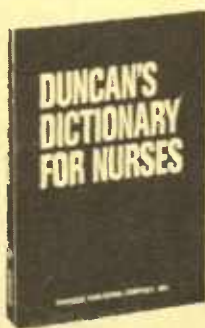
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Around the world — in 80 minutes, or less

Wouldn't you like to take a round-the-world trip without ever leaving Canada? Impossible? Not when you realize that Metro Caravan is scheduled to coincide with the CNA convention in Toronto this June and that means your chance to sample the culture, entertainment, foods and beverages of 50 countries — all for the price of a passport, a few subway tokens, and a little spending money.

Caravan transforms community centers, clubs and churches throughout the city into international pavilions representing the great cities and countries of the world — Amsterdam, Damascus, Krakow, Munich, Rome and Tokyo to name a few.

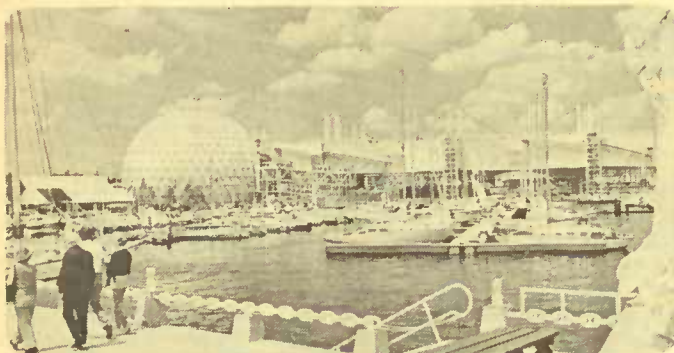
Since its inception ten years ago, Caravan has grown to national and international prominence as the largest annual community festival of its kind in the world.

Passports and travel information will be available at RNAO's Hostess Desks at the Royal York Hotel from noon on Sunday, June 25th. You can either set off on an adventure on your own or with an RNAO tour guide.

RNAO hostesses also will have information about a variety of other sights and sounds of Toronto you'll want to see and hear during your visit.

RNAO Welcomes Delegates

Members of RNAO's Reception Committee will be at Terminals 1 & 2 at the Toronto International Airport and at Union Station to greet and direct out-of-towners. And, there will be Information Desks at the Royal York Hotel and other major downtown hotels on Sunday, June 25th. From Monday, June 26th through Wednesday, June 28th, hostesses at Information Desks in the Royal York Hotel will have information to help you enjoy your visit to Toronto.

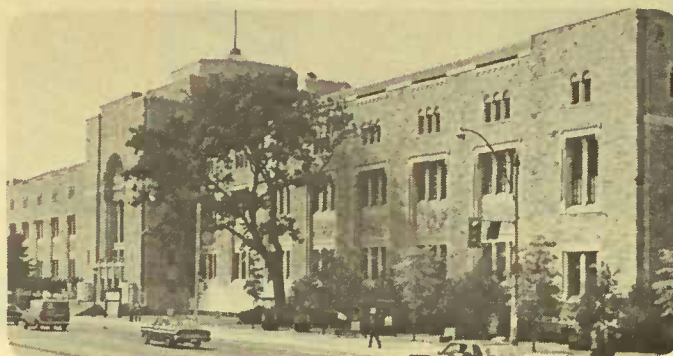


Ontario Place

There will be passes to Ontario Place, a 96-acre parkland of lakes, lagoons, islands and canals situated on the Toronto waterfront. This popular attraction contains the Forum — an amphitheater in the classical Greek tradition of the theater-in-the-round — where programs range from classical to contemporary. Cinesphere, a globe-shaped motion picture theater, houses a screen six stories high and cruises of the Toronto Islands and Harbor originate here.

Metro Toronto Zoo

Thousands of native and exotic animals and plants from Africa, Australia, Eurasia, Indo-Malaysia, North America and South America are on show at the Zoo.



Royal Ontario Museum

Interested in ancient Chinese art? The ROM has an excellent collection alongside notable examples of art from India, Japan, Europe and England. Next door is the McLaughlin Planetarium which holds regular star-gazing shows.

Art Gallery of Ontario

Just a pleasant walk from the Royal York Hotel, the Art Gallery of Ontario houses the largest public collection of Henry Moore sculptures in the world and a collection of Canadian painting and sculpture second only to the National Gallery in Ottawa. The Grange, tucked in behind the AGO was the Gallery's first home; it is decorated in the style of the 1830s.

Toronto City

There's also Casa Loma, the CN Tower, the City Hall, shopping at the Eaton Centre or at the boutiques along Yorkville and Cumberland. There's Black Creek Pioneer Village, a glimpse of 19th century rural Ontario. There's interesting dining at a variety of ethnic restaurants. There's theater and cabaret.



And there's Exercise

Bring your jogging gear and join "Nurses Running for the Health of it." Regular exercise breaks also will occur during the educational and business sessions of the convention.

And all of this is only a backdrop to the stimulating program developed by your program committee.

**Toronto will be great in '78.
Why not plan to be there?**

Canadian Nurses Association 1978 Annual Meeting and Convention

**25-28 June 1978
Toronto, Ontario**

The 1978 Annual Meeting and Convention of the Canadian Nurses Association will be held 25-28 June 1978 in the Canadian Room of the Royal York Hotel, Toronto, Ontario.

The opening ceremony will be held Sunday evening, 25 June 1978 at 19:00 followed by a reception for members and students registered for the meeting. Sessions will begin at 09:00, Monday 26 June 1978, continuing daily and concluding Wednesday 28 June 1978 at 17:30 with the President's Reception.

Students enrolled in schools of nursing in Canada may register to observe the proceedings of the Annual Meeting and participate in the program and social events.

- At what point do the rights of the client come into conflict with the commitment of professionals to saving lives?
- What is the potential of scientific research and development for negative impact on our human and humane practice?
- What is the nature of the difficulties nurses face, here and now, in relation to ethical issues in nursing practice?
- What changes are needed in nursing education, basic and continuing, if professionals are to be prepared to meet the serious challenges they will face in practice?
- What is the nature of ethical issues faced by nurse researchers? in relation to rights of clients? in relation to the nurse researcher?
- What mechanisms are needed at the level of the professional association to support individual nurses, monitor the extent of the problem as it exists now, and as it will change through time?
- What is the experience of the individual nurse? How will she deal with her conflict of conscience, and conflict with others?

It is the answers to these and similar questions that will, to a large extent, determine the future of the nursing profession.

At one time in our professional lives we could safely assume that "a cardiac arrest = a cardiac arrest = a death." But scientific technology has changed all that and ipso facto put decision-making regarding life and death into the hands of health care professionals.

Lacking guidelines and as unprepared to deal with our new and awesome responsibilities as the society of which we are a part, we have addressed the situation case by case.

Inevitably, *quality* of life has become an issue. We have wondered too, about quality of life as it relates to a *health* focus for the society at large.

And about the impact on the family of these decisions, is the quality of their lives affected adversely? What is the cost to society? Is it a legitimate question, in ethical terms, to consider "cost" in the decision-making process about an individual life?

Old age. The hazards of nuclear energy. Do we, as health care professionals have an ethical responsibility to participate in decisions about the environment? Dissemination of information about environmental hazards? Exposure hazards in the work situation?

Health care professionals have heretofore struggled with these questions in the privacy of their work place, either alone or together with one or two of their peers. Sometimes, nurses have found themselves in conflict with the families of their patients. Often, their views have been in conflict with other members of the health team.



David Roy



Laurier LaPierre



David Suzuki

Now, the time has come to address these issues openly and collectively. That is why the members of the planning committee preparing for the 1978 meeting of the Canadian Nurses Association have chosen "Ethical Issues in Nursing" as the convention theme.

That is why they have invited speakers like **J. David Roy**, mathematician and philosopher, director of the Center for Bioethics, Clinical Research Institute of Montreal, to come to the convention and identify and analyze ethical issues facing the profession on the basis of actual case histories presented by nurses from across the country.

That is why, too, **Laurier LaPierre**, popular television personality, will interview three well-known nurses about ethical issues in nursing research during a roundtable discussion.

Dr. Abbyann Lynch, St. Michael's College, University of Toronto, will present a paper on ethical issues as they affect nursing education.

Marguerite Schumacher, dean, faculty of nursing, University of Calgary and past president of CNA, will discuss the challenges faced by the professional association, and Canada's principal nursing officer, **Josephine Flaherty**, will address the experiences of the individual nurse in "Current conflict and a look toward the future."

The 1978 theme is generated from very deep levels of public concern. With this in mind, one of the convention highlights, will be a public lecture by **David Suzuki**, world-renowned geneticist, on "The Frontiers of Science and Humanity." This keynote address is scheduled for presentation on the second evening of the convention and the public will be invited.

Your professional association is offering you this opportunity to share in the search for answers to some of the most important concerns that face nurses today. There will be no final answers. The hope is that you will be stimulated to ask even more questions — and accept responsibility in the search for mechanisms to deal with the ethical issues which are of such deep concern to society and to us.

Glaucoma: Dialogue

It is always disturbing to find a writer legitimately cloaked with professorial authority who has failed to fully research important aspects of a subject he writes about especially in an article intended to inform practicing professionals. It is equally serious if through inadequate inquiry into the legal status and current education and training of another profession, an authority imparts erroneous information about this profession, since biases may be established that prevent interaction beneficial to the public.

Such is the case in "Glaucoma — Awareness Prevents Blindness" authored by assistant professor Eileen French of the University of Ottawa. Her paper errs in important aspects.

For example the paper says, "it is a common belief that there is a relationship between vascular hypertension and ocular hypertension (glaucoma) but such is not the case." This view is an old one presented by Duke-Elder but recently refuted by Hayreh in the British Journal of Ophthalmology, Volume 56 (No.3) pp. 175-185, 1972 in which he states, "(glaucoma) is a disease wherein the normal balance between intraocular pressure and the blood pressure in the choroidal vessels supplying the optic disc and the retrolaminar part of the optic nerve is disturbed resulting in vascular insufficiency in the optic disc and the retrolaminar part of the optic nerve, and hence in visual field defects and pathological changes in the optic disc and nerve."

Stephen Drance of the University of British Columbia also reported glaucomatous, optic disc and field changes in persons with normal intraocular pressures who had suffered precipitously low blood pressures resulting from trauma and surgery. It has also been demonstrated that a high positive correlation exists between I.O.P. (intraocular pressure) and B.P. (blood pressure) and an I.O.P./B.P. ratio is of some predictive value in glaucoma screening. Thus while no relationship has been demonstrated between the disease entities, essential hypertension and glaucoma, vascular hypertension and hypotension are important variables in relationship to the optic nerve head and the retina in the disease glaucoma.

French equates ocular hypertension and glaucoma and they are not synonymous. Glaucoma is a disease in which there is loss of visual function or alteration of ocular structure which follow or are present with ocular hypertension.

French goes on to state: "It has been shown that eye pressure is not significantly changed by smoking or drinking alcoholic beverages," in a discussion directed toward patient education. While it is true that no direct or immediate effects have been shown, the adverse effect of both alcohol and tobacco on the vascular system are well known. Thus it would be better to advocate that health counselors advise patients to eliminate smoking and to limit their use of alcohol when they suffer from glaucoma.

French did the public a disservice when she did not update her knowledge of the role and scope of optometrists in glaucoma detection. This is a grave omission since optometrists are a primary point of entry to the health care system for a substantial portion of the Canadian public.

- The optometrist is trained to detect glaucoma and may legally use eye drops (topical anesthesia) in the process. The optometrist is also trained to take an ocular health history and in the process to enquire about familial aspects of glaucoma. This important factor in glaucoma detection is not even mentioned in French's paper.

- Optometrical examinations include at least one kind of tonometry as routine since it is part of a legal standard in optometric practice. Generally a form of applanation tonometry, either a Goldmann with a biomicroscope or an electronic tonometer is used. Air-pulse and tonomat applanation tonometers are also widely used.

- The Schiotz (indentation tonometer) as displayed in a picture accompanying the paper is now seldom used since it has a higher risk of corneal abrasion and provides less reliable I.O.P. measurement. The picture accompanying the paper displays poor technique as the instrument is not vertically aligned on the cornea, thus the pressure reading would be erroneous. However optometrists do receive training in the use and precautions for carrying out the technique properly.

- The taking of visual fields both central and peripheral by means of tangent screen and perimeter are also part of the optometric examination when indicated.

- The optic nerve head and retina are also examined as a routine part of optometric glaucoma detection and many optometric and ophthalmologic practitioners agree that a large proportion of glaucomatous eyes are originally detected by this important technique in which optometrists receive rigorous training.

In most communities today, optometrists and nurses constantly interact for patient benefit. It is essential that no misunderstanding of their respective roles or their scope of activity be engendered or sustained.

Any nurse wishing information on optometry can obtain it from the Canadian Association of Optometrists, 210 Gladstone Ave. Suite 2001, Ottawa, Ontario, K2P 0Y6 or the School of Optometry, University of Waterloo.

— M.E. Woodruff, Professor, Director, School of Optometry, University of Waterloo, Waterloo, Ontario.

The author replies

In answer to M.E. Woodruff's letter: The use of the word "disturbing" "disservice" and other such references to my paper are regretted. However, I wish to reassure Mr. Woodruff that indeed, much research was done for this paper, and it has been reviewed by competent authority. I wish to rebut several of his comments.

My article stated that vascular hypertension is not related to glaucoma. Mr. Woodruff admits that no relationship has been demonstrated, then uses this as a springboard to state the pathophysiology of *hypotension*. It was not my intention to cover this aspect. There is a correlation between vascular *hypotension* and intraocular pressure (I.O.P.). Dr. Stephen M. Drance in his article "Visual Field Defects," *Clinical Ophthalmology*, Vol. 3, Chapter 49, 1976, pp. 12 and 13 writes:

"The progression is not related only to levels of intraocular pressure. Many other factors should be taken into account. Visual field defects may occur or progress as the result of the medical reduction in systemic blood pressure or as a result of a reduction in blood pressure due to hemorrhage or myocardial infarction. If blood pressure rises and remains at previous levels, progression in the visual field deficit may be halted.

Further field loss may result from continued episodes of reduction in perfusion pressure. In other patients, classic glaucomatous visual field defects develop with little rise in intraocular pressure. In these patients, other factors, usually small vessel disease, account for the ischemia of the optic nerve head. Also, these patients are likely to have a continued reduction in their field of vision unless their intraocular pressures are so significantly changed as to improve the perfusion of the optic nerve head, and this improved perfusion is difficult to achieve".

Woodruff further states that I have equated ocular hypertension and glaucoma and that they are not synonymous. Strictly speaking, ocular hypertension and glaucoma are not synonymous terms, but for the purpose of this article (aimed at nursing and allied paramedical personnel) they should be dealt with similarly. Dr. Stephen Drance, in the article "Chronic Open Angle Glaucoma — Present and Future, the Second Spaeth Lecture," *The Canadian Journal of Ophthalmology*,

October, 1977, Volume 12, No. 4, page 254, states:

"I must stress that in the present imperfect state of our knowledge, there is no valid reason for thinking that glaucoma and ocular hypertension are two diseases."

Anyone who has had one pressure reading above normal should be referred to an ophthalmologist for further evaluation. Too many patients are not referred by people who do not have the ability to detect early disc and field changes and other risk factors.

Perhaps Woodruff should re-read page 24 of my article (The Role of the Nurse) where I have emphasized family history and screening. This hardly suggests that medical history taking is limited to nursing. In glaucoma assessment, one of the basic parameters is gonioscopy, and only an ophthalmologist can carry out this examination with expertise.

With regard to tonometry, I am well aware that other health care personnel do carry out some types of tonometry testing. In addition to ophthalmologists, family doctors carry this out routinely in their offices using mainly the Schiotz tonometer. Incidentally the diagram was never intended to train someone in the use of the Schiotz but merely to demonstrate the size and ease of carrying out this procedure.

My article stated that smoking and drinking do not significantly change I.O.P. Woodruff again admits the statement is correct, but takes off on his own discussion. My intention was certainly not to advocate the excessive use of alcohol or smoking. Excessive use of either can be deleterious to any system in the body and alcohol has been known to cause decreased I.O.P.

I referred to the role of the optometrist, optician, and ophthalmologist in a broad sense only, and it was not my intention to get into the curriculum of each. The importance of the role and scope of optometrists in glaucoma detection may be a point of view held by optometrists alone, and not necessarily those who actually manage glaucoma patients.

In conclusion it was never my intention to enter into discussion regarding the philosophy and curriculum between different health disciplines. However, the best trained individual for treating glaucoma is the ophthalmologist, who is a trained medical doctor as well as a specialist in eye diseases and surgery. Since the final result of any patient with eye disease is to see an ophthalmologist, then early referral to him may prevent delay in treatment and prevent further damage. The patient has a right to get the best treatment at the earliest indication of eye disorders, including glaucoma and my conviction is that the ophthalmologist must be consulted as early as possible for diagnosis and treatment.

— Eileen (Clapin) French, Assistant Professor, University of Ottawa, School of Nursing.

saving dollars

THE EASY WAY

Mike Grenby

The best — the easiest — way to save money is to let somebody else do the job for you. Your job is to be a nurse, not a super-efficient money manager. But that doesn't mean you can't learn how to make the most of each paycheque and, in spite of inflation, finish 1978 with a little nest egg that you can put towards whatever it is that you have decided is worth saving for.

We're only human. Once we have the cash in our hands, it's far easier to spend than save. The secret is to find ways of making some of that cash inaccessible. After all, you can't spend money you don't have.

The following ways of saving money all work. Pick the approach(es) that appeals to you, depending on your particular situation and how much you want — or need — to save.

1 Payroll deduction

Some hospitals and other employers will deduct a fixed amount of money (which you specify) from each of your paycheques, or perhaps from every other paycheque.

The money might go toward buying a Canada Savings Bond for you, or be deposited in your hospital credit union account, depending on the plans available.

Sometimes you can arrange to have your paycheque deposited directly to your bank account.

Check with your personnel or payroll department to see if any of these services are available. If not, perhaps a group of nurses could ask to have one of these services provided.

2 Automatic account transfer

When you get paid, you probably either cash your cheque or put the money into your chequing account, or possibly your saving-chequing account.

Drop in to see the manager at your bank, trust company, credit union, etc. and ask for suggestions to help you save money.

One of the easiest ways is to open a non-chequing, true savings account if you don't already have one. Then ask the manager to transfer \$25 or \$50 from your chequing to your savings account every payday.

The manager might even have suggestions for other savings instruments which will pay more interest.

This money can be available to you if you need it for an emergency, but you have to make the withdrawal in person — just that much more difficult than simply writing a cheque.

Some nurses I know have even opened their savings accounts at a place right across town, to make it even more inconvenient to withdraw the money.

3 Family allowance cheque

If you have children, this is an ideal way to build up a nest egg, ideally for the child but it could provide a reserve for the parent(s), too.

Each month, put the family allowance cheque into a non-chequing savings account.

If you start when a child is born, you could easily build up around \$10,000 by the time the child turns 18.

And every time the account has accumulated \$500 or \$1,000, you could earn even more interest by buying a Canada Savings Bond or savings certificate. Again, ask your manager what's available.

4 Joint signature account

If you don't feel that any of the methods described so far would protect you from yourself — you'd still take out the money — then consider a joint signature non-chequing savings account.

You'd set this up with your spouse or a responsible, money-conscious friend.

Then, every time you wanted to withdraw any money, you'd need his or her signature as well as your own.

5 "Manager's permission" account

Not all branches will offer this, but it's still worth asking for a non-chequing savings account that would need approval from the manager or deputy every time you wanted to make a withdrawal.

saving dollars

THE
EASY
WAY

6 Borrowing to save

None of the aforementioned forced savings techniques costs anything. And so nobody will monitor what you're doing to make sure you are indeed putting money aside regularly.

If you respond only to the summons of the bill-collector, then consider taking out a loan and investing the money in a high-interest savings certificate.

Let's say you go to the bank or credit union to borrow the money. Provided you're going to use the money to invest in a savings certificate offered by that place, you should be able to bargain for a lower-than-usual loan interest rate.

For example you take out a five-year \$3,000 loan at 10 percent and possibly put the \$3,000 into a five-year savings certificate paying 9 percent.

Because you're paying off the loan, the amount of the loan goes down from month to month, so you don't pay interest on the entire \$3,000 for five years.

However, the \$3,000 investment is earning interest on the entire amount for the five years.

So at the end of five years, your \$3,000 investment will have earned more interest than you had to pay on your \$3,000 loan. What's more, you may deduct your loan interest for income tax purposes.

I don't have the space to go through the exact figures, so ask your bank, credit union, etc. manager or loan manager to show you how this works. And if one place won't provide this service, try somewhere else.

7 Life insurance

Life insurance is intended to insure your life, not save you money.

And so it's one of the worst, most expensive ways to save money.

After all, you're helping to pay for the salesman's commission as well as the life insurance company's expenses and profits.

Life insurance has been rated as one of the worst investments. It might be better than nothing, but not much, so try all the other ways of saving money first.

If you have any questions on your personal finances — involving insurance, banking, income tax, credit, investment, etc. — write to me c/o The Canadian Nurse.

While I cannot reply individually, I shall answer as many questions in this column as space allows.

Letters must be signed, but only your initials will be used if you so request.

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Glossary:

Canada Savings Bond: A bond which may be cashed in at any time and earns interest practically up to the day you cash it in. Usually sold only in the Fall. May be bought for cash or through the instalment plan.

Chequing account: The account on which you write your cheques. Some trust companies and credit unions offer free cheques while other places levy a service charge for each cheque you write. These accounts usually pay no interest.

Non-chequing savings account (also called true savings account): You may not write cheques on this account and can withdraw money only in person. Your money earns interest.

Savings-chequing account: You get a few free cheques, depending on how much money you keep in the account. Very little interest is paid on your savings. In general, you should avoid having an account like this. Instead, use a chequing account for your cheques and a non-chequing savings account for your savings.

Savings certificates: You buy a savings certificate for a fixed period of time, usually anything between 30 days and six years, and get a fixed rate of interest on your money for that period. Banks and credit unions usually let you cash in the certificate ahead of time (you pay a penalty for this privilege) while trust companies usually don't allow early withdrawal. Always ask about this point. 4



Mike Grenby, author of "Saving dollars the easy way," is on the staff of the Vancouver Sun, lectures and appears regularly on both local and national radio and television, and has done consulting work for the federal government.

A graduate of the University of British Columbia and Columbia University Graduate School of Journalism, he is the author of "Mike Grenby's Guide to Fighting Inflation in Canada" (International Self-Counsel Press Ltd.). He and his Australian-born wife, Mandy, who is a nurse, live with their son, Matthew, in West Vancouver.

Clinical Wordsearch no. 10

This is another in a continuing series of clinical wordsearch puzzles relating to different areas of nursing, by Mary Elizabeth Bawden (R.N., B.Sc.N.) who presently works as Team Leader in the Rheumatic Diseases Unit, University Hospital, London, Ontario.

Solve the clues. The bracketed number indicates the number of letters in the word or words in the answer. Then find the words in the accompanying puzzle. The words are in all directions — vertically, horizontally, diagonally, and backwards. Circle the letters of each word

found. The letters are often used more than once so do not obliterate them. Look for the longest words first. When you find all the words, the letters remaining unscramble to form a hidden answer. This month's hidden answer has six words. (Answers page 4).

T S I G H T C I P O C S O R C I M
O S S D S I G S S S I A H T D F C
P P I I N O R T U E R R S N I K O
H L H L T I O R O S I E A R P O N
T P I T U I L A E S S L E E L O J
H A I P H C R B U A G C E V O B U
A Y N N U A O I Q L M S E R P T N
L I D I E P L S A G U P S E I N C
M S A S T I G M A T I S M N A I T
O U T Y F E I U O C L A E C M R I
L M H T O R R S A S I I Y I O P V
O G G S C E T N R Y C P E T C E I
G A I A U G T A E N R O C P U G T
I T L L S H O R B I T Y P O A P I
S S B L A Y F I N G A M A E L A S
T Y S L I R I D O T O M Y S G L E
S N E L R E C L U L A R E L C S S

- 1 The eye, the visual centre in the brain and the optic nerve are all involved in _____ (5)
- 2 Deviation of the eye in which the visual axes are not physiologically coordinated. (10)
- 3 Characterized by increased intraocular pressure, this condition is more in diabetics and the over-forty group. (8)
- 4 Characteristic of mice who travel in threes. (5)
- 5 Involuntary rapid movement of the eyeball. (9)
- 6 Watered-down humor. (7)
- 7 Not seen with the naked eye. (11)
- 8 Short sightedness. (6)
- 9 An error of refraction in which parallel light rays fail to come to focus on the retina. (11)
- 10 The clear transparent anterior covering of the eye. (6)
- 11 A glass for converging or scattering rays of light. (4)
- 12 Double vision. (8)
- 13 Slender hairlike process on outer edge of eyelid. (6)
- 14 May be dilated or constricted. (5)
- 15 Usually coloured, like a flag. (4)
- 16 Inflammation of 15. (6)
- 17 Innermost of the three tunics of the eyeball, surrounding the vitreous body and continuous posteriorly with the optic nerve. (6)
- 18 Common eye colour for blondes. (4)
- 19 It moves when you blink. (3)
- 20 White of the eye. (6)
- 21 Item sought in revenge. (3)
- 22 A hordeolum. (3)
- 23 Inflammation of the thin membrane that covers the eyeball and lines the eyelid. (14)
- 24 Sensory pathway conveying visual impulses from retina to the occipital lobe of the brain. (5, 5)
- 25 What an eye and a space-ship have in common. (5)
- 26 Tear factory. (8, 5)
- 27 Instrument for viewing the interior of the eye. (14)
- 28 Pertaining to that fold of skin covering the inner canthus of certain races. (10)
- 29 Defect on surface of 20. (7, 5)
- 30 Incision of the iris. (9)
- 31 Another term for ophthalmologist. (7)
- 32 Some are bifocals. (7)
- 33 Enlarge (7)
- 34 Scouf (anagram) (5)
- 35 Needed for cigarettes and reading. (5)
- 36 M. D. specializing in disorders of the eyes. (15)
- 37 Available from most public libraries for those with difficulty seeing. (5, 5, 4)
- 38 Describing size of constricted pupils. (3)

LISTENING FOR THE DEATH-BELLS

IF *a critically ill, apparently competent patient informs his doctor that he refuses further treatment, must his wishes be followed? Who ought to be involved in deciding not to offer a patient further medical treatment? the nurse? the doctor? the family? the hospital administration? What medical conditions justify removal of life-sustaining equipment? What is the potential liability of the doctor who engages in any form of euthanasia? What about the nurse who carries out a no-resuscitation order?*

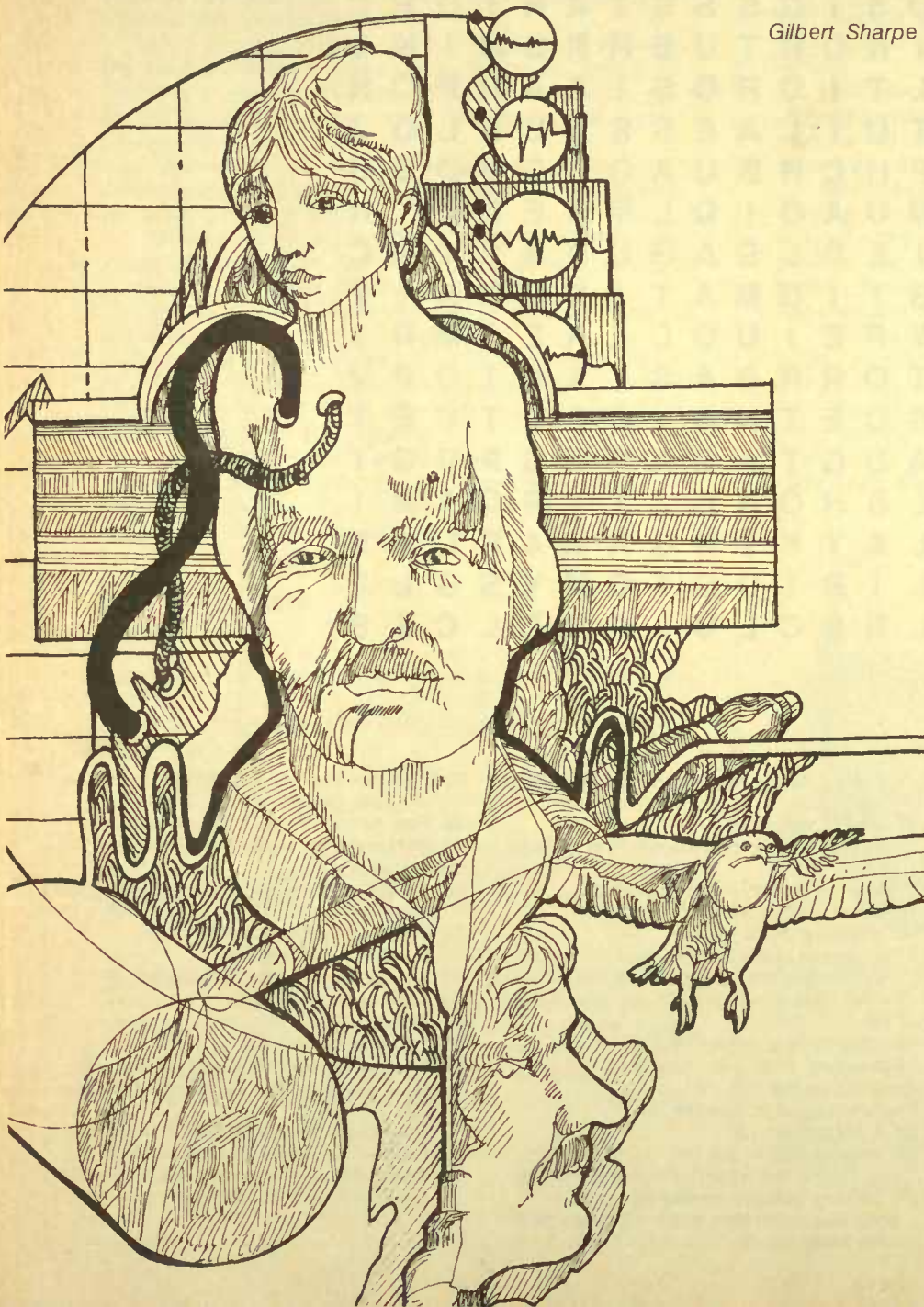
Gilbert Sharpe

Euthanasia — whether voluntary or passive — has become one of the most talked-about issues of our time. What is all too often forgotten in these discussions, however, is the simple fact that, in almost every case that involves the death of a patient in an institutional setting (and 80 percent of deaths do occur in an acute or long-term care setting), it is the nurse who is the health professional most immediately and directly affected.

It is the nurse who is the frontline worker who is called upon to implement the doctor's no-resuscitation order. And, if the Courts decide that charges under the Canadian Criminal Code are warranted, it is the nurse who will be charged with a criminal offence for carrying out this order.

In a recent criminal action against four nurses in an Ontario Psychiatric facility, criminal charges were brought against the nurses on the grounds of assault. In fact, the nurses were following the instructions of a physician to administer an intra-muscular injection to an hysterical patient. In order to do this, it was necessary for the nurses to physically restrain the patient. Although they were subsequently cleared of any criminal wrong-doing or professional misconduct, it is important to note that the charges were brought, not against the physician issuing the instructions, but rather against the nurses implementing them.

As a general rule, the role of a hospital nurse is to implement instructions by physicians as quickly and competently as possible. However, nurses as professionals owe primary responsibility to their patients. This makes it important for them to exercise a measure of independent professional judgment. Rather than blindly following physicians' orders when they are in doubt as to the appropriateness of these instructions, they would be better advised to first confirm their instructions with that physician. If they are still in doubt as to the appropriateness of the instructions, they should contact their supervisor and note their instructions and concerns on the chart.



Euthanasia

Most patients view hospitals with a mixture of apprehension and security. They expect that once hospitalized they will have the advantage of obtaining whatever treatment they need immediately. Moreover, the law has always implied a privilege on the part of medical personnel to treat the unconscious victim of an accident because of that victim's presumed intentions to receive treatment. Physicians assume that patients desire a chance of recovery. Even when a patient expresses a death wish, physicians tend to override it. They presume that if the patient knew his condition, he would have chosen life over death.

Where a patient is conscious and competent, he must be consulted prior to taking any course of action. Relatives possess no authority to consent on behalf of a patient in such circumstances. A terminally ill patient who is competent does have the right to refuse life-saving treatment. This position raises some practical difficulties. For example, can a terminally ill patient make a balanced, voluntary judgment when his suffering is clearly distorting his mind? What of the patient who executes a "living will" expressing his intention that he not be resuscitated? Or that he not receive life-saving treatment should certain conditions develop at a later date? Can a patient's act be voluntary by prior consent?

What if he later decided to retract this prior statement but cannot do so because of his incompetency? How can a man decide the degree of distress that he is likely to tolerate at some future date? Should safeguards be imposed on such a practice requiring individuals to have executed such a will within the past year and under a notarial seal? If a patient who is critically ill but apparently competent informs his physician that he refuses to receive any further treatment, must his wishes be followed? Should his motivations be examined? What if he is worried about being a financial and emotional burden to his family? What if he is in a post-operative depression?

Duncan Vere, in his text "Voluntary Euthanasia", cites the case of a man who suffered so much during two resuscitations that he asked that, in the event that cardiac arrest should recur, he be allowed to die. The arrest occurred but he was again revived. Two years later the patient was at the center of a happy family, apparently in perfect health, and had forgotten the distress of his resuscitations. Heifetz, consulting neurosurgeon in the Quinlan case, says that

"most patients who ask for death reject it when faced with it."

The right of a physician to negate his patient's wishes can only be in the direction of prolonging life. A patient's normal role is one of passivity and trust in his physician. The training of medical practitioners has always been towards the preservation and prolongation of life. If patients were made aware of the ability of their physicians to make decisions as to when to end life, would this not jeopardize their confidence in the intent of their physicians to cure and heal? Would they see their physicians as the suspected purveyors of death? Would physicians then have a duty as part of their responsibility to make full disclosure to their patients to inform them as to whether or not they perform the function of placing such orders on patients' charts?

The right to die

Who ought to be involved in making the decision not to offer a patient further medical treatment where the patient is not sufficiently competent to render an informed judgment? The legal authority of relatives in these circumstances is unclear. May they consent to a course of action which will "harm" the patient? In somewhat similar circumstances in the United States where incompetent patients are used as live organ donors, hospitals seek court authorization before proceeding. It is interesting to observe American courts going through the charade of construing a psychological benefit to the incompetent individual before giving their authorization to proceed and remove his kidney.

In this country, relatives are viewed as having no authority because of the "harmful" results of the authorization. There is another important consideration mitigating against placing such decisions in the hands of close relatives: following the death of a loved one, relatives often suffer from so-called "survival guilt." Consider the additional burden they would of necessity assume should they have the ultimate say in authorizing the cessation of further treatment. Also, which relative is to have priority where several of them disagree?

Courts, whose concept of power over the incompetent person has always been one of "protection," are loathe to make decisions in these circumstances. To place such power in the hands of the hospital administration would also be unacceptable. There might be a perceived temptation on the part of hospital personnel to accelerate the

act of dying in terminal patients so as to make available required beds in the hospital. Apart from the feeling by hospital personnel that the terminally ill are occupying beds needlessly, there may be a sense of futility on the part of the staff because of their inability to alleviate the ills of these individuals.

In 1974, a poll conducted by *Modern Medicine* revealed that 61% of Canadian physicians felt that a committee of physicians should be the ones to make the decision whether or not to discontinue life-support for an unconscious, dying patient. In the Quinlan case, the court held that such decisions are of necessity medical ones and not for the judiciary to make. They ruled out the relatives as ultimate decision-makers with the statement that "it may be concurred in by the parents, but not governed by them." The Superior Court of New Jersey directed that Karen's attending physicians should consult with the hospital ethics committee and if that body agreed with them that there was no reasonable possibility of her ever emerging from her present comatose condition to a cognitive, sapient state, then the present life-support system could be withdrawn without any civil or criminal liability on the part of any participant, whether guardian, physician, hospital or others. The court added a statement indicating that in the future, there would be no necessity to bring an action to the courts for the implementation of comparable decisions in the field of medical practice and future decisions should be made along the lines laid down in this case.

A definition of death

If these decisions are left to physicians what criteria are they to employ? The British Medical Association declares that it is a clinical decision when to regard death as imminent, but cautions that it is not entirely unusual for patients to make unexpected recoveries. Consider the prognostic uncertainties. Can death be predicted with fair certainty? What probability of recovery is acceptable as a condition precedent for removing life-sustaining equipment? One percent? Five percent?

What medical conditions qualify for removal of life-sustaining equipment? A survey of Ontario physicians conducted in 1971 revealed widespread disagreement over criteria for a definition of death. Although brain death was given a slight preference by physicians, consider the fact that Karen Quinlan failed to meet the

Harvard criteria of brain death and yet the court indicated its willingness to permit the respirator to be removed. By suggesting that individuals condemned to a comatose state need not be maintained on life-sustaining equipment, the court appeared to broaden the conditions established by the medical profession for the cessation of treatment in these cases and to define new standards of action. The court instructed that the final decision is to be left in the hands of attending physicians and hospital ethics committees. It remains to be seen whether Canadian courts will adopt a similar stance when confronted with similar circumstances.

Legal problems

Two distinct arms of the law may be set in motion against Canadian physicians who engage in any form of euthanasia. A *civil action* may be successfully brought against such a physician if his decision in this matter is not consistent with the standard of care expected of a reasonable physician in similar circumstances. The argument might also be raised that once a physician undertakes to render necessary medical services he remains under a legal duty to perform them if by omitting to do so life would thereby be endangered. Thus, a physician practicing so-called "passive euthanasia" who refrains from administering medical aid to a patient "in extremis" on the grounds that the patient's death is inevitable in any event, could well face such common law sanctions.

Conversely, a dying patient who is mentally competent and refuses further treatment has a right not to have his personal integrity infringed. This right is recognized in law by the intentional tort of battery. A physician's usual defence against such an accusation is the existence of the patient's consent to the procedure. When this is not forthcoming, an action framed in battery may be successful. However, where the result of the physician's intervention is beneficial to his patient, it is unlikely that a court would award any more than nominal damages. Certainly, the potential damages for withholding treatment are far greater than those which could result from treating without consent.

Condonation of a practice which a court labels as "bad" raises the spectre of liability on the part of hospitals as well. Physicians, viewed for years by the legal process as independent contractors for whom the hospital bears no vicarious responsibility, are gradually coming under the umbrella of the hospital whose status as provider of services



to the community carries with it certain legal obligations. Thus, hospitals may be well advised to take a greater hand in policing practices with such potential liability.

Criminal liability

The area of law which should be of greatest concern to Canadian physicians is a potential *criminal charge*. Sections 198 and 199 of the Criminal Code provide that individuals undertaking to administer medical treatment to others are under a legal duty to use reasonable knowledge, skill and care in so doing. Also, those who undertake an act are under a legal duty to perform it, "if omitting to do so is or may be dangerous to life." The physician who leaves instructions not to provide medical treatment to his terminal patient could be considered to have contravened this section of the Code and might, therefore, be prosecuted — as could the nurse who follows his instructions or the hospital where this happens.

The potential for a civil action framed in negligence against a physician was raised earlier. The analogous action in Criminal Law appears in Section 202 of the Code which defines criminal negligence as "doing anything or omitting to do anything that it is one's duty to do in such a way as to show wanton or reckless disregard for the lives or

safety of other persons." The potential for a charge here should be obvious.

An act of *commission*, such as turning off a respirator, as opposed to an act of *omission*, such as the failure to take appropriate action in an emergency, is more likely to attract a charge under the homicide sections of the Code.

- Section 205 provides that a person commits homicide when, directly or indirectly, by any means, he causes the death of a human being.
- Subsection 5 provides that a person commits culpable homicide when he causes the death of a human being by criminal negligence.
- Section 212 provides that culpable homicide is murder where the person who causes the death of a human being means to cause his death.

While the argument may be made that, in this case, the doctor is merely permitting nature to take its course, the fact is that as a result of his instructions, or actions, death occurs in a setting where prompt action might have averted such a result, if only for a short period of time.

Two other sections are worthy of consideration.

- Section 207 holds that where anyone, through an act or omission, does anything

that results in the death of a human being, he causes the death of that human being notwithstanding that death from that cause might have been prevented by resorting to proper means.

Section 209 states that where anyone causes bodily injury to a human being that results in death, he causes the death of that human being notwithstanding that the effect of the bodily injury is only to accelerate his death from a disease or disorder arising from some other cause.

Thus, it becomes an interesting question when a respirator is removed from a terminal cancer patient and death quickly ensues whether the true, immediate cause of death of that patient is the cancer, or the act (and resulting "injury") of removing the respirator.

While the Criminal Code does not envisage the hospital as its chief forum for the commission of the offences enumerated above, the acceleration of death by omission or commission may well invite an action against a physician or even a nurse or other employee who would then be forced to fall back on the rather poor defence of "everyone is doing it — why pick on me?"

Doctors argue that these practices accord with sound medical practice. They are supported by public statements from their professional association and by the fact that such practices are common in most hospitals. However, until legislation defining the parameters of medical procedures in these situations is forthcoming, I believe that hospitals would be unwise to continue to sanction such practices. At the very least, they should establish rigid guidelines for their utilization.

Changing the laws

Is a legislative response appropriate here? In 1971, the British Medical Association, after exhaustive consideration decided that euthanasia legislation could never provide adequate safeguards. Their decision was based in part on the many errors that are made every day in medical diagnosis and prognosis, in assessing terminal stages of illness, and in the validity of a request for euthanasia.

It is true that several American states have attempted legislation in this area. In 1976, the State of California enacted the Natural Death Act. This Act expressly authorizes the withholding or withdrawing of life-sustaining procedures from adult patients afflicted with a terminal condition where the patient has executed a directive in the form and manner prescribed by the Act. This

directive would generally be effective for five years after the date of execution unless it were revoked sooner in a specified manner. The Act relieves physicians, licenced health professionals acting under the direction of a physician, and health facilities from civil liability, and relieves physicians and others mentioned from criminal prosecution or charges of unprofessional conduct for withholding or withdrawing life-sustaining procedures in accordance with the provisions of the Act.

At least one Canadian province has already attempted to define death in such a manner that would recognize something less than the necessity for obtaining a cessation of heartbeat and respiration as the only acceptable criteria. In Ontario an Act Respecting the Withholding or Withdrawal of Treatment Where Death Is Inevitable has received second reading in the Legislature. This Act is similar to the California Act referred to above. It must be noted, however, that while the State of California could make provision exempting physicians from responsibility under the Criminal Code of that state, Canadian provinces have no such authority. Thus, regardless of the form of provincial legislation in this area, physicians remain exposed to all the tenants of criminal responsibility discussed above.

Both the California Act and the Ontario Bill are valiant attempts to define all of the conditions which the British Medical Association feared could not be sufficiently covered so as to adequately safeguard the rights of individuals. Whatever their respective strengths and shortcomings, however, it is sufficient for our purposes to point out the futility of the exercise in Canada without the cooperation of the Federal Government in amending its Criminal Code.

Moral issues

The legal problems that surround euthanasia are apparent. Before resolving these, however, we must come to grips with other aspects of this topic. Does society have an investment in human life and the concept of its sacredness that overrides, if not legally, at least morally, the rights of the individual? Does the right to die, in effect, sanction unconscious, self-destructive impulses in people? Is it just another escapist system in a world looking for easy answers to the human dilemma?

In places where so-called "right to die" legislation now exists, a form similar to the living will now used in the United States is always provided. Individuals sign these forms

at a time when they are not immediately concerned with their own death. The form becomes operative at a time when they are obviously 100 percent involved. When they are unconscious, they are obviously unable to rescind such direction.

Let us hope that the social issues will be resolved before lawyers are required to grapple with the legal issues in our courts and before over-zealous legislators foist an impractical solution upon us. ♣

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Acknowledgment: This article is based on a paper the author delivered to the 1976 annual meeting of the Ontario Hospital Association.

The "death-bells" in the title of this article are a reference to "a tinkling in the ears, supposed by the Scottish peasantry to announce the death of a friend." (Brewers, Dictionary of Phrase and Fable).

children with strabismus

As a nurse, you may be the first person to encounter a child with untreated strabismus, particularly if you work in the area of public health. Strabismus, or "crossed eyes" must be detected and treated early in the child's life, or he may develop permanent impairment of vision. What can we do to help? In the following article, author Maureen Rooney tells us something about strabismus, and our role in its detection and treatment.

Maureen Rooney

The term strabismus refers to a deviation in the alignment of the eyes. In strabismus, also called squint or crossed eye, one eye is in a deviated position so that the visual axes are not straight in the primary position. The deviation may be such that the eye turns inward (convergent), outward (divergent), upward (elevated), or downward (depressed); there may also be a combined horizontal and vertical deviation of the affected eye.

Often strabismus can be found to be hereditary in origin. About 70% of all cases of strabismus are of the convergent type; half of these are present at birth or develop shortly afterward. The remainder usually develop between the ages of two and five years. Strabismus developing in older children and in adults is more likely to be of the divergent type. Occasionally, a sudden change in the alignment of the eyes, particularly after the age of six, may be an indication of a more serious underlying disorder, such as a neurological problem or tumor.

Methods of treatment for strabismus may include the use of glasses, occlusion, drops, prisms, or surgery, and very often a combination of these methods is necessary. The success of any form of treatment depends upon the early detection and initiation of treatment, preferably before the age of six.

Anatomy and physiology review

In order to understand strabismus, a brief review of the anatomy of the eye and the visual apparatus of straight eyes is necessary.¹ The human eyeball is almost spherical in shape, except for the front part which is occupied by the transparent cornea. The wall of the globe consists of three major layers: the sclera, the choroid, and the retina. The innermost layer, the retina, contains the visual receptors, the rods and cones, specialized nerve cells that respond to light stimulation.

Straight back from the pupillary opening, there is an area of the retina that is free of blood vessels called the macula. The fovea is a shallow depression in the macula, densely packed with cones that yield the highest visual acuity.

Each eye is moved by six ocular muscles that are innervated by the third, fourth and sixth cranial nerves.

Binocular vision involves fusion, the integration by the brain of two separate images into one. An image is presented to each eye; it travels along the visual pathway to the brain where the two images are joined, then projected and seen as one. A child with normal straight eyes is able to develop fusion in the first few years of life. Fusion enables the individual to appreciate stereoscopic vision or depth perception. In children with strabismus, fusion of images and therefore depth perception, will be poor or nonexistent.

Anomalies

Various congenital anomalies prevent the normal development of the visual functions, thus preventing fusion from occurring and producing a deviation in one eye. Some of these anomalies may include:

- partial or complete ptosis
- microphthalmus
- congenital cataract
- retinoblastoma
- cerebral palsy
- retrolental fibroplasia
- uncorrected high refractive errors.

The placement of the eyes either too close or too far apart can hinder fusion and result in an inward or outward deviation of one eye. This condition is sometimes evident in patients with:

- Crouzon's disease
- hypertelorism
- hydrocephalus
- mongolism.

Congenital abnormalities in the development of the orbits, muscles, or in the visual or nerve pathway often result in some form of strabismus. Birth trauma may also result in strabismus.²

Pseudostrabismus

Broad epicanthal skin folds in babies can sometimes create what is known as pseudostrabismus⁹ which is the appearance of strabismus without any real deviation. Often parents will wrongly feel that their child is cross-eyed for this reason.

In some cases, these skin folds can also mask a crossed eye. When any suspicion of strabismus exists, it is best to have the opinion of an ophthalmologist. If a child has strabismus, it will not go away.

It is important to know that no one ever outgrows a crossed eye. Left untreated, a strabismus present at the age of two is almost always present at age twenty. Moreover, a child is never too young for examination — even at birth, an ophthalmologist can diagnose strabismus, detect any pathology that may be present and counsel the family regarding future management.

Amblyopia ('Lazy eye')

When one eye is deviated, the two foveas are not able to fix on the same object, so that the patient will initially have double vision (diplopia). A child will only tolerate diplopia for a very short time — quickly he learns to suppress the image received by the turned eye.

As the child continues to suppress the image received by the turned eye, the vision in that eye deteriorates very rapidly. This reduced vision is referred to as amblyopia, or 'lazy eye'.

Amblyopia can develop quickly, especially in a very young baby. If the child with amblyopia does not receive medical attention until he is eight years of age, attempts to recover his vision are often unsuccessful.

It is important to realize that the angle of the deviation has no bearing on the degree of amblyopia. The length of time amblyopia is left untreated is crucial to the recovery of lost vision.

The treatment of choice for amblyopia is the occlusion of the better seeing eye. This forces the child to use the fovea of the turned eye and so restore vision to the eye. Occlusion, only one step in the treatment of strabismus, restores vision to an amblyopic eye, but further treatment must then be carried out to correct the deviation.

Surgical results for strabismus are more successful when the patient has equal vision before the operation. When a child is able to alternate, that is use one eye and then the other, amblyopia will not likely occur. Each fovea is stimulated alternately so that amblyopia will not develop.



Maureen — right convergent strabismus



Diane — right divergent strabismus



Corwin, without his glasses — right convergent strabismus



Corwin, with his glasses on — straight eyes with fusion

Occlusion Therapy

Amblyopia is treated through the use of a patch to occlude the better seeing eye. The patch is usually placed on the face, or, in some cases, worn on the glasses. Once the patient's vision has improved, he is gradually weaned from the patch by wearing it for a shorter period of time each day. Occasionally, the patient's vision will get worse when he is weaned from the patch, and occlusion therapy must be resumed. Parent and child need a great deal of encouragement during this difficult period of time. It has been found that patching a favorite toy or drawing pictures on the patch can make occlusion a game and therefore a more tolerable experience for the child.

With the cooperation of parents and child, patching can be a successful method of restoring vision to an amblyopic eye, but the success of treatment will be limited as the child grows older.

Vision testing

Most vision testing methods are based on the standards of the Snellen chart, with the patient sitting twenty feet from the chart and reading the smallest print he can distinguish. Testing the vision of even a very young child is not as difficult as one might expect. Even testing those who cannot yet identify letters is quite simple.⁴

Vision is always tested in one eye at a time; for testing children, it is best to occlude the eye with a patch since the child will tend to peek if just using a card or his hand. Single letters are also much easier for a child; often he will find a full chart confusing.

If the child cannot identify letters, he can be given a card with some letters on it. He merely points to the letter on the card to match the one the examiner is projecting at a distance of twenty feet.

If this method is not possible, then the illiterate E test can be used. The child holds a big E in his hand and turns it to match the one shown or held at twenty feet.

With small infants, the examiner can estimate vision by having him follow a small toy, or pick up small beads from his hand. If the child objects more strongly to having one eye covered than the other, there is reason to suspect amblyopia, and the child should be examined by an ophthalmologist.

Refractive errors

Refractive errors occur when the image of the object does not fall on the retina. If the image is focused in front of the retina, the person will be short-sighted or myopic; if the image is focused behind the retina, the person is long-sighted or hyperopic. A person with unequal curvature of the cornea is said to have astigmatism. The optical correction needed to focus the image on the retina will result in good vision. The need for glasses does not mean that an individual has 'bad' or unhealthy eyes.

If strabismus is present, glasses alone may not correct a crossed eye. The child may also require occlusion, drops, bifocals and/or surgery.

Points to remember

There are important points to remember about strabismus if nurses are to be helpful in guiding parents to seek correction for the eye defect in their child:

- a child never outgrows strabismus
- strabismus is often hereditary, but can occasionally be due to an underlying disorder
- a child is never too young to be examined by an ophthalmologist
- the treatment of strabismus involves many forms of therapy
- the importance of early detection, diagnosis, and treatment of strabismus must be stressed
- 'lazy eye' or amblyopia can result in permanent impairment of vision unless treated early in the child's life. ❖

Maureen M. Rooney, author of "Children with strabismus," is an orthoptist, specially trained to carry out tests for the assessment of visual acuity, binocular and stereoptic status of the eyes. After two years of training in the Orthoptic Clinic, University Hospital, Saskatoon, Saskatchewan, Maureen received her Canadian Orthoptic Certificate. Presently, she is employed by Dr. George Gilmour, an ophthalmologist in Prince Albert, Saskatchewan. Seminars and lectures with student nurses prompted the idea to publish information on strabismus for the benefit of all nurses.

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Chad — occlusion patch worn under glasses

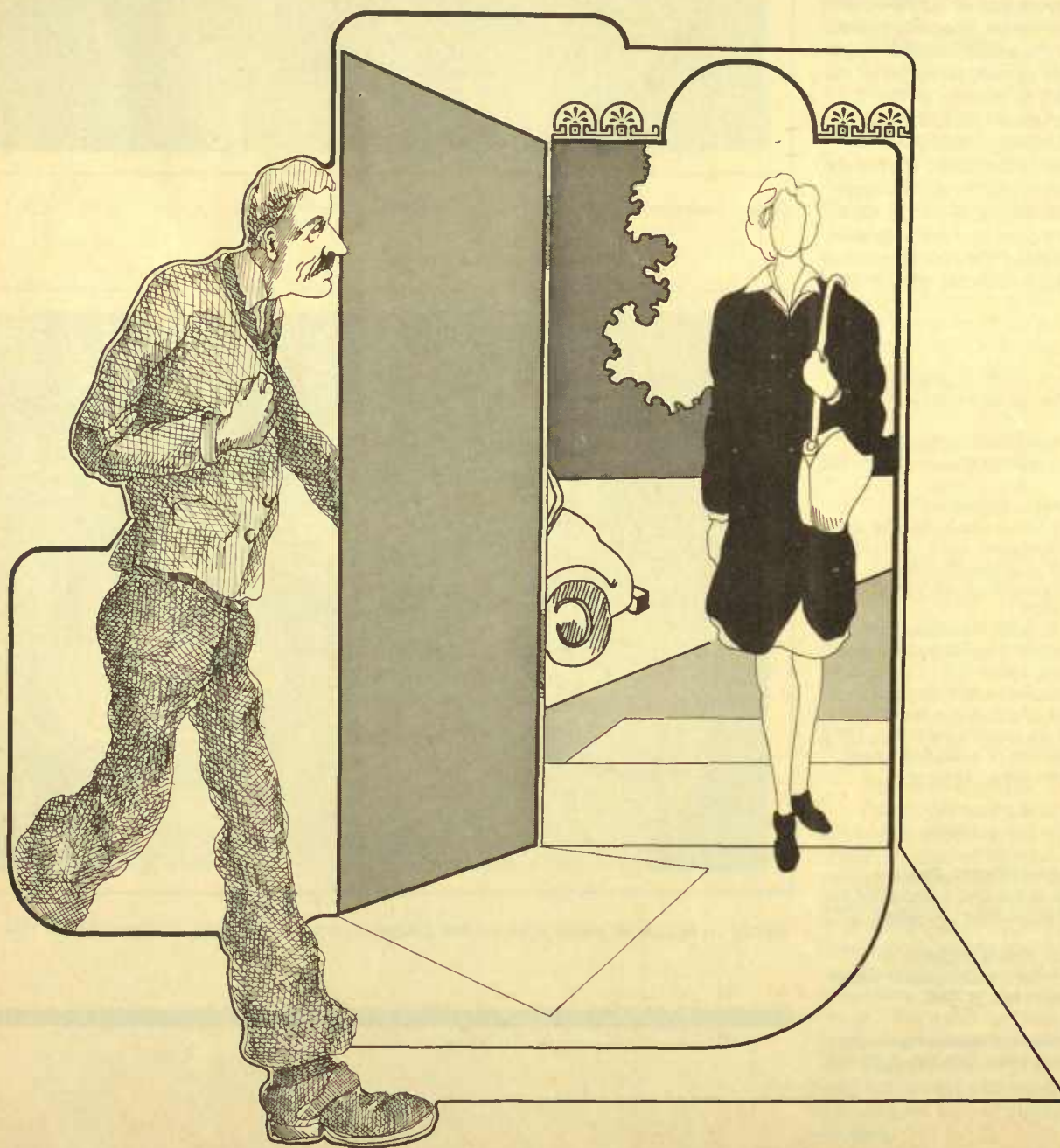


Wendy — occlusion patch worn on the glasses

RESPIRATORY NURSING

Increased knowledge in respiratory physiology and medicine has given the patient with chronic respiratory dysfunction a new lease on life. But what he does with it depends largely on how he learns to live outside the protective environment of the hospital.

In the following articles, authors Peggy Atkins and Carol McFadyen describe a project to bring respiratory nursing into the community, helping patients to maintain their independence and become responsible participants in their own health care.



A COMMUNITY APPROACH

Peggy Atkins

Recently, many new dimensions in the delivery of respiratory health care have come to light. One approach involves the nurse specialist working in the community. As respiratory nurse in the South Okanagan Valley, I work in and with the community to improve many aspects of respiratory health.

The Respiratory Nurse Program is a unique method of health care delivery. Because the program is a joint effort between the South Okanagan Health Unit and Kelowna General Hospital, I am able to utilize the health care services of both agencies to offer optimum support and education to patients in transition from an acute care setting to the community.

An important goal in health care is to make therapy *patient-directed* rather than *physician-directed*. To realize this goal, we have concentrated our energies on education, rehabilitation and preventive care. As respiratory nurse, I find it possible to coordinate the various community facilities so that they function as a team working toward a common goal — a patient who maintains his independence and dignity, and who is a responsible participant in his own health care.

This is how we got started ...

The beginnings

It was in January of 1975 that a proposal for a Respiratory Nurse Program was submitted to the B.C.T.B. Christmas Seal Society. The objectives of the program were geared towards the support of respiratory patients, their rehabilitation and education, and the prevention of respiratory disease. These objectives have never been viewed as distinct components, but rather as a unit to provide the foundations for a comprehensive community respiratory health program. It was anticipated that the nurse would establish programs to meet the unique needs of our community. The programs that have evolved have been aimed at the individual and at the community as a whole.

Plans for a respiratory nurse became a reality in May of 1975. Carol McFadyen undertook the initial organization, and had successfully completed a good deal of the

groundwork when I assumed the position in January of 1976. A "home base" was required to allow contact with the community, the hospital and other health care professionals. An office in the Health Unit permitted close contact with the community health and home care nurses. By sharing an office at the hospital, I became a recognized team member in both agencies. Dr. W.W. Arkinstall, a respirologist in our community conceived the respiratory nurse position and, as medical advisor for the program, he continues to offer his support and direction.

The Kelowna Puffers Club

Kelowna boasts a warm, dry climate which has long attracted both people of retirement age and those with respiratory dysfunction. A priority of our respiratory nurse program was the provision of support, education and direction in respiratory care, that members and their families need to cope with respiratory disabilities. The Kelowna Puffers Club is our attempt to fill this need.

Within the Club, I act as a resource person, helping to find speakers, answering questions and seeking out information. Group discussions provide one of the most useful aspects of the Puffers Club, allowing members to share problems and solutions to their problems. As a nurse, I find the discussions as helpful as the members; although I am not troubled by respiratory disease, our talks give me considerable insight into how it really feels to have a chronic lung disability. This insight has proven invaluable to me in all aspects of my role as respiratory nurse.

Smoking education

The Puffers are those who already have chest disease. We felt that, for the program to be more comprehensive, we should look towards the other end of the scale — to those who have not yet developed lung disease.

For this reason we began a program to educate school children about the dangers of smoking, beginning with elementary school children between the ages of 10 and 13.

My presentation to the children is informal, and I encourage their

participation. I discuss normal respiratory function and then tell them how smoking affects their lungs. I follow my talk with a film "Smoking — It's Your Choice," and generally the film is followed by lively discussion among the students.

Since we began the program, I have given this presentation to over 6,000 students. A videotape of one of these presentations allows students in other areas to participate in this aspect of the program.

The Division of Vital Statistics has evaluated the effects of this program with the following results:

- Children involved in the presentation have indicated a definite increase in knowledge about respiratory function.
- They have also shown an increased resolve not to smoke.

Family Asthma Program

As nurses most of us have at one time or another, encountered the frustrations and anxieties inherent in caring for the asthmatic child and his parents. An important part of our program lies in aiding the young asthmatic to deal with his asthma.

Twice yearly, with the help of two physiotherapists, I conduct an eight-week program dealing with 15 asthmatic children and their parents. This program aims at increasing the knowledge of both parents and child about asthma and decreasing the dependence of the child and his family on the asthmatic condition.

The asthmatic child and his parents attend weekly sessions that include exercises with a physiotherapist, group discussions, and swimming. Separate evening sessions are held for parents.

Because changes in pulmonary function have been disappointing as an indicator of the success of other programs, we have taken a different approach in evaluating this program. We felt that its value should be reflected in the child's day to day function such as increased social and physical activity, decreased school absence, or decreased dependence on formal medical therapy.

The Family Asthma Program is being evaluated by monitoring

parameters of the child's function of daily living and his dependence on his condition. The analysis by the Division of Vital Statistics is ongoing; preliminary results indicate that:

- both parents and children show an increase in knowledge about asthma;
- increased awareness reduces anxiety in both parent and child; it also reduces unnecessary restriction of the child's activities;
- children taking the program seem to have increased activity levels and decreased asthma dependence.

These preliminary results are very encouraging. However, the success of the program can perhaps best be measured — not through statistics — but through the reactions of children taking the program. Comments like the one made by a ten year old graduate two months after he completed the program are most encouraging to me: "I can play baseball now, cause Mom knows that I know what to do when I get tight. And, you know what? . . . This asthma thing doesn't scare me so much anymore. Besides, lots of kids have got it!"

Patient consultations

Perhaps the most challenging feature of my role as respiratory nurse lies in patient consultations. These come to me by referral, either from a family physician or consultant. My function in this respect is to identify the patient's problems and aid in finding workable solutions.

Any patient who is chronically ill can live a full life if we give him the knowledge and tools to help himself. So many times, patients hesitate to ask about their illness or their therapy because they are afraid of looking foolish or imposing on their doctor's time. I find that meeting a patient in his home, where he is comfortable and secure, encourages him to ask questions and seek the direction he needs in order to stay well and live at his maximum level.

Some of the problems I encounter in patients with chest disease are relatively straightforward, requiring personalized education and some direction in self-care. Others require comprehensive teamwork in order to

find solutions. In the article that follows Carol McFadyen describes the case of Mr. Lane, a man who required considerably more than routine care. 4

Peggy Atkins is a graduate of the Vancouver General Hospital School of Nursing. She worked as an Emergency Room Nurse in Kelowna General Hospital before assuming the position of Respiratory Nurse in January 1976.

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THE RESPIRATORY NURSE IN ACTION

Carol McFadyen

When I first met 86-year-old Mr. Lane, he received me with a shaky nod and an asthmatic rasp, his 'hello', somehow unconvincing. Today a different Mr. Lane meets me at the door — confident, his hand extended in welcome.

What Mr. Lane needed was individual care, based on understanding of his own particular problem. As respiratory nurse, it was up to me to find out what the problem was, so that specific and helpful therapy could be initiated.

Mr. Lane had suffered from progressive shortness of breath (intrinsic asthma) for several years, a condition that was complicated by congestive heart failure and recurrent respiratory infections. For some time, his activity had been limited to bedrest with occasional brief excursions to his easy chair.

On several recent occasions, Mr. Lane had been admitted to hospital with dyspnea. The most striking feature about his symptoms was that his breathing difficulties generally worsened at night, and responded in a positive way to the reassuring presence of a professional. Mr. Lane always improved dramatically once he arrived at the hospital, without any radical change in his medical management.

Because the explanation for his recurring night symptoms was unclear, I was asked to see him and to assess his home situation. When I first met him, he had just been discharged from the hospital with the diagnoses of congestive heart failure, asthma, and anxiety reaction.

My first visit with Mr. Lane and his family made one thing very clear — the man was generally very nervous — a constant worrier. He admitted openly that he tended to panic at night. When I talked about his panic with him, I found that he was afraid of the night, and the associated lack of access to medical assistance.

As we talked, he told me that he had nearly drowned as a child, and that every time he grew short of breath, his old fear recurred. He was afraid to go to sleep, in case he awakened short of breath and unable to get help, afraid that he would die during one of his night attacks.

Reading through Mr. Lane's medical records, I noted that all five of his most recent hospital admissions had taken place in the early morning, following a night of severe breathing difficulty and panic. My perusal of the nurses' notes told me that he frequently expressed fear of the dark and of being 'left alone.' On one occasion he had been readmitted in bronchospasm on the day following his discharge from hospital — when he recovered immediately in emergency, he attributed his rapid recovery to "clear hospital air."

At the time of his last admission to hospital, I had identified Mr. Lane's problem of nocturnal dyspnea as an acute anxiety reaction related to his fear of dying and to his near drowning. Consequently, it was decided that Mr. Lane might benefit from a referral to Dr. J.B. Moir for hypnotherapy, so that he might be helped to deal with his specific anxieties. I kept in touch with Mr. Lane during the time of his hypnotherapy treatments.

Hypnotherapy was not used to replace medications, physiotherapy or other treatments but as an adjunct to other methods used. While he was under hypnosis, suggestions were made to him that his subconscious mind would review and assess the ingrained fears and tensions that were contributing to his anxiety and therefore increasing his bronchospasm and dyspnea. It was suggested to him that these reactions would be discarded or modified on a subconscious level.

Mr. Lane responded dramatically following his first hypnotherapy session. During subsequent sessions, he continued to improve but at a less spectacular rate. After this treatment, he was not readmitted to hospital, and house calls made by his family doctor were cut in half.

I continued to visit Mr. Lane every week in his home in order to reassure and support him so that his breathing difficulties were controlled on a continuing basis. Over the ensuing weeks, I noticed that Mr. Lane became more adept at dealing with his asthma spells without panic.

Seeing Mr. Lane at home enabled me to understand more about him as an individual. His treatment in hospital had

always been based on relief of his immediate symptoms, but successful treatment of Mr. Lane depended upon further assessment, treatment and continuing support. When I visited him at home, it was possible for me to gain further understanding of his respiratory symptoms, the sequencing of these symptoms, and their relationship to his own very individual situation.

As I got to know Mr. Lane, I was better able to identify the precipitating factors surrounding his attacks. This led to specific therapy and marked improvement in Mr. Lane's ability to deal effectively with something that touched his whole life, his respiratory condition. As respiratory nurse, I am able to assess and support Mr. Lane on an ongoing basis. ♡

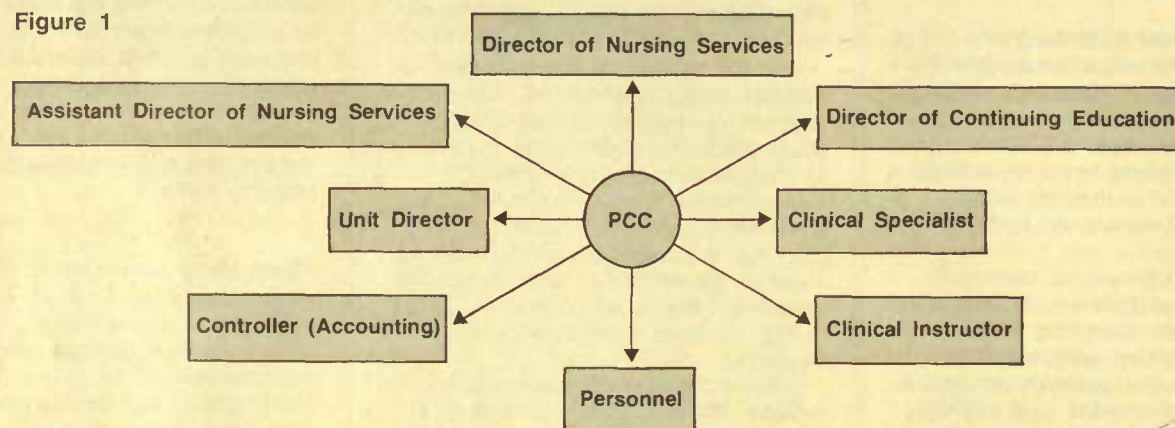
Carol McFadyen initiated the Respiratory Nurse role in Kelowna, a pilot project sponsored by B.C.T.B. Christmas Seal Society, and administered jointly by the South Okanagan Health Unit and Kelowna General Hospital. She is currently a lecturer in the new Diploma Nursing Program at Okanagan College, Kelowna, B.C.

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FROM HEAD NURSE TO NURSE MANAGER

McMaster University Medical Centre has combined the traditional roles of head nurse and supervisor to create a new role of "middle manager." Far from being just another cog in the nursing machine, this middle manager functions as leader, problem solver and decision maker on the unit or ward, the place where good management counts most.

Figure 1



The organizational structure of many hospital nursing departments is based on a pyramid-shaped hierarchy. Power rests at the top with the director of nursing services and filters down through the assistant director of nursing, the supervisors, to eventually reach the head nurse.

In this kind of organization, the head nurse, the person responsible for patient care on the unit, is *not* in a position of power. If, for example, ward problems arise that involve other hospital departments, they are often taken to the supervisor or higher authority rather than to the head nurse. This kind of roundabout communication is not only inefficient but it means that a person unfamiliar with the problem on a day-to-day basis is the one who must resolve it. And how long does it take for this decision to be made?

At McMaster University Medical Centre in Hamilton, Ontario, alternatives to this

hierarchical nursing organization have been developed over the past five years. Here, the emphasis is on decentralization of nursing authority so that direct power and responsibility for problem solving rests with the people on the unit or ward. For people accustomed to working in a hierarchical structured hospital, this represents a considerable shift in power, one that is perhaps difficult to imagine.

To accomplish such a shift, the McMaster University Medical Centre has developed a different approach to the head nurse role. In their organization the roles of head nurse and supervisor have been effectively combined into a new role of "middle manager." These middle managers have been termed Patient Care Coordinators (PCC). With 24-hour-a-day responsibility for all aspects of care on their units, their job is not an easy one. But as one PCC put it: "There are no clipboard supervisors, the

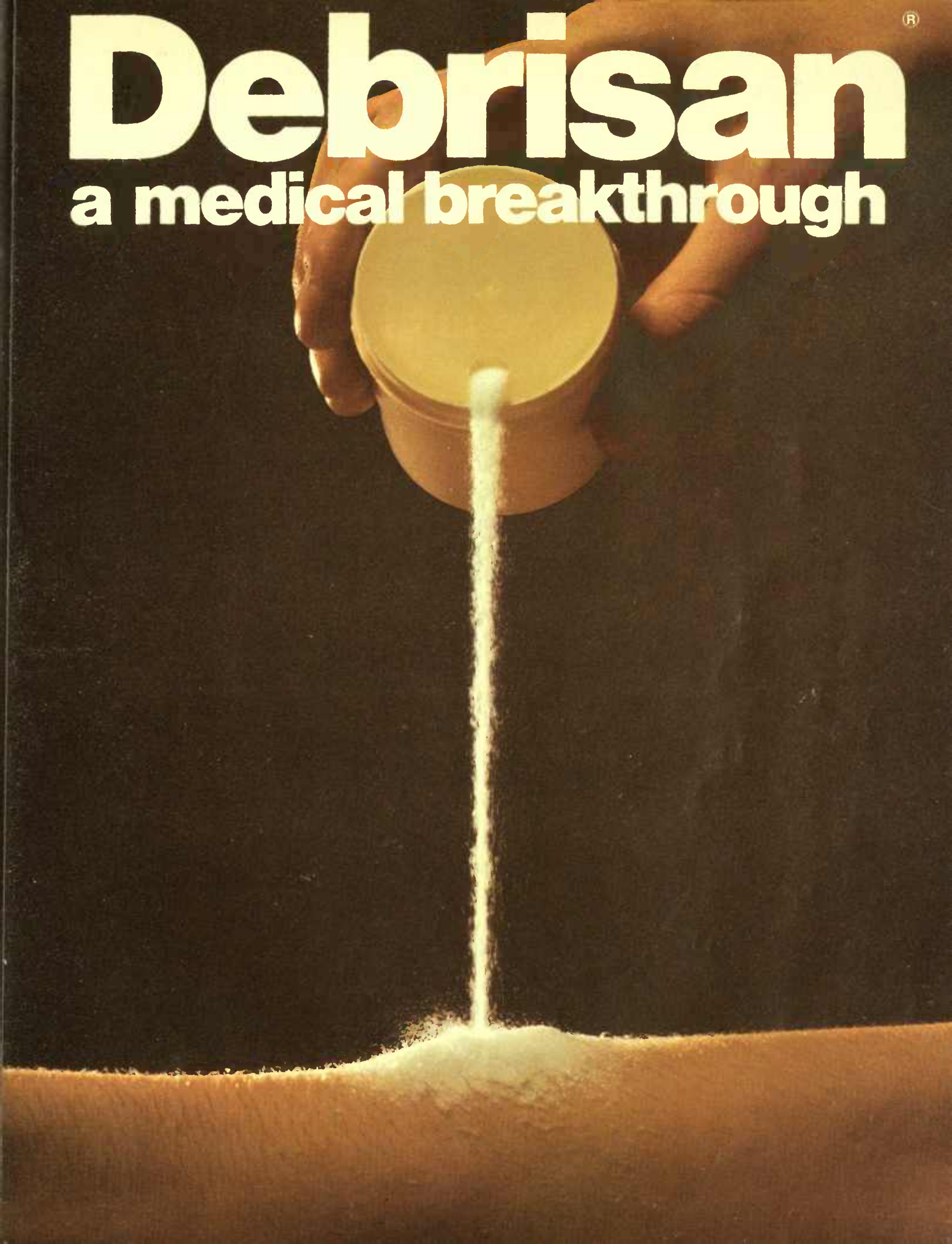
staff is our own, the unit is our own. We have direct communication with our staff, with physicians and with other hospital departments as equals. Problems get solved at the unit level, where they should be."

PCC's responsibilities

In a decentralized organization like McMaster where decision making is at the unit level, Patient Care Coordinators function in an expanded role, a role that demands heavy responsibilities. They are directly responsible for the quality of nursing care delivered and for the day-to-day organization and management of their unit or ward. This includes coordinating the activities of both allied health professional and support personnel who come to their units as workers, consultants or suppliers of services. For example, personnel from housekeeping, social work, nutrition and central processing departments are responsible to the PCCs

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1. Infected exuding ulceration following a tibial fracture.
2. 7 days. The wound was cleansed and granulation developed.
3. 30 days. Ten days after successful grafting.¹



1. A 62 year old male with a large venous leg ulcer which resisted various local treatments for 23 years.
2. 6 days. The wound was cleansed and granulated.
3. 21 days. Thirteen days after successful grafting.²



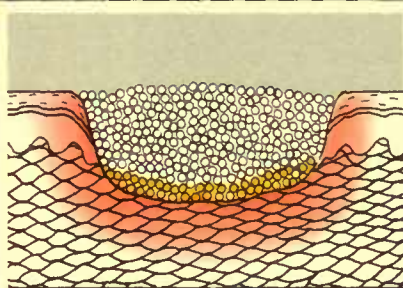
1. An 83 year old male with a decubitus ulcer showing a heavy growth of *Proteus mirabilis* resistant to penicillin G and V, erythromycin and doxycycline.
2. 29 days. The wound culture was negative.
3. 64 days. A minor wound remained.¹

could change the way you think about skin ulcers.

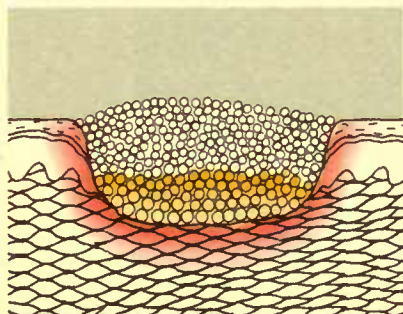
a unique mode of action

unaffected by bacterial drug resistance

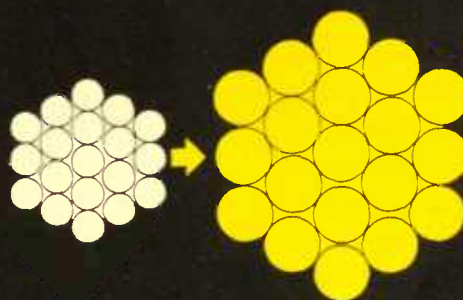
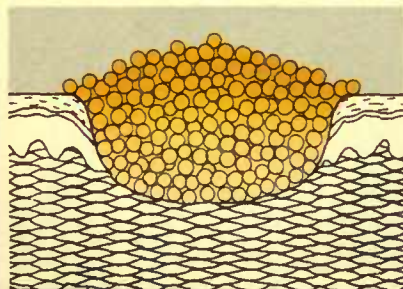
1. A thick layer of Debrisan is poured on the wound.



2. Absorption begins almost immediately. The Debrisan beads swell as they lift the exudate away from the wound.



3. After several hours, absorption is complete. The beads are saturated and the wound surface is cleansed.



Because Debrisan's action is physical, not chemical, it is not impaired by bacterial drug resistance. When poured on a wound, Debrisan beads absorb four times their weight in exudate, providing a clean environment to enhance natural healing.

Continuous wound cleansing and drainage
Debrisan continuously absorbs bacteria, toxins, fibrinogen and inflammatory mediators.

Debrisan cleans the wound quickly and keeps it clean.

Debrisan prevents eschar and crust formation.

Debrisan

gentle and easy to use

Debrisan is non-sensitizing, non-irritating, non-toxic and gentle to use, unlike conventional techniques which often irritate injured tissues. It has no known contraindications or side effects and is well tolerated, even by patients who have become sensitized to other treatments.

Full product information on request.

1. Data on file at Pharmacia (Canada) Ltd.
2. S. Jacobsson et al., Scand J Plast Reconstr Surg 10:65-72, 1976

Debrisan
continuous wound drainage.



® AD. T.M.

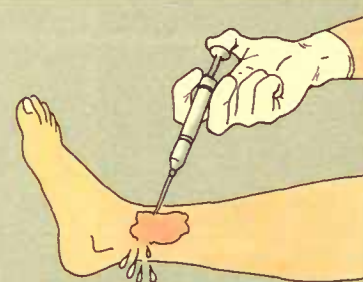
Pharmacia (Canada) Ltd.
2044 St. Regis Blvd.
Dorval, Quebec

Application

1. A thick layer of Debrisan is poured onto the wound crater and the wound is bandaged. After a few hours, the beads are inspected. When they become saturated, they turn from white to a greyish-yellow colour.



2. Saturated beads are rinsed away and replaced with a fresh layer.



This procedure is repeated 1-3 times a day, depending on the rate of discharge, until the wound remains clean.



Indications

Debrisan is effective whenever continuous drainage and cleansing are required: infected suppurating wounds such as stasis and diabetic ulcers, burns and infected traumatic wounds. Debrisan is not effective on dry wounds.

Contraindications

None known.

Side effects

None known.

Caution

Keep away from eyes.

while working on their units.

Total responsibility involves all aspects of unit activity including administration, staffing, education and research as well as day-to-day management. PCCs are responsible for:

- interviewing, hiring, evaluating, and terminating nursing staff;
- involvement in the hiring of other allied health professionals who will be working on their units;
- interpreting and implementing policies and procedures;
- investigating physicians' and patients' complaints;
- planning and participating in staff and student education;
- planning and implementing an orientation program for all health professionals involved on their units;
- monitoring clinical research;
- preparing an annual budget and maintaining ongoing control of expenditures;
- maintaining their own clinical expertise.

In consultation with the director of continuing education, PCCs decide on the number of students that can be accommodated on their unit at any one time. Independently they decide on the allocation of funds in their operational budget and the time spent in inservice education and orientation for staff.

Head nurses in the traditional hierarchical system may say that they have been functioning in a similar role for years. But what is apparent in this decentralized organization is that PCCs have the power to implement the decisions they make. In other

words, they are in a position of authority when it comes to unit problems, authority that is backed up by the director of nursing services.

Since there are no supervisors, PCCs are on call on a rotational basis to handle nursing problems that may develop on the units between 1730 and 0730 hours during the week and on the weekends. An administrator is also on call to advise the PCC on problems dealing with administrative rather than nursing matters. As problems arise, the PCC on call provides the senior level nursing expertise which may be needed for staffing, policy and procedure problems. The PCC helps nursing staff solve these problems and if appropriate follows them up with that unit's PCC later.

Accountabilities

The hospital is set up on a matrix organization in which some people wear more than one hat e.g. the PCC who has clinical responsibilities in Obstetrics or in the Neonatal Intensive Care Unit also is accountable to the director of the perinatal program.

The increased responsibility of the PCC at the unit level demands a change in the traditional working relationships that have existed within the nursing department itself and with other hospital departments. Interdependency is the goal. At McMaster the Patient Care Coordinator shares responsibilities and accountabilities with other hospital personnel resulting in relationships that are different from those in the traditional hierarchy. As middle

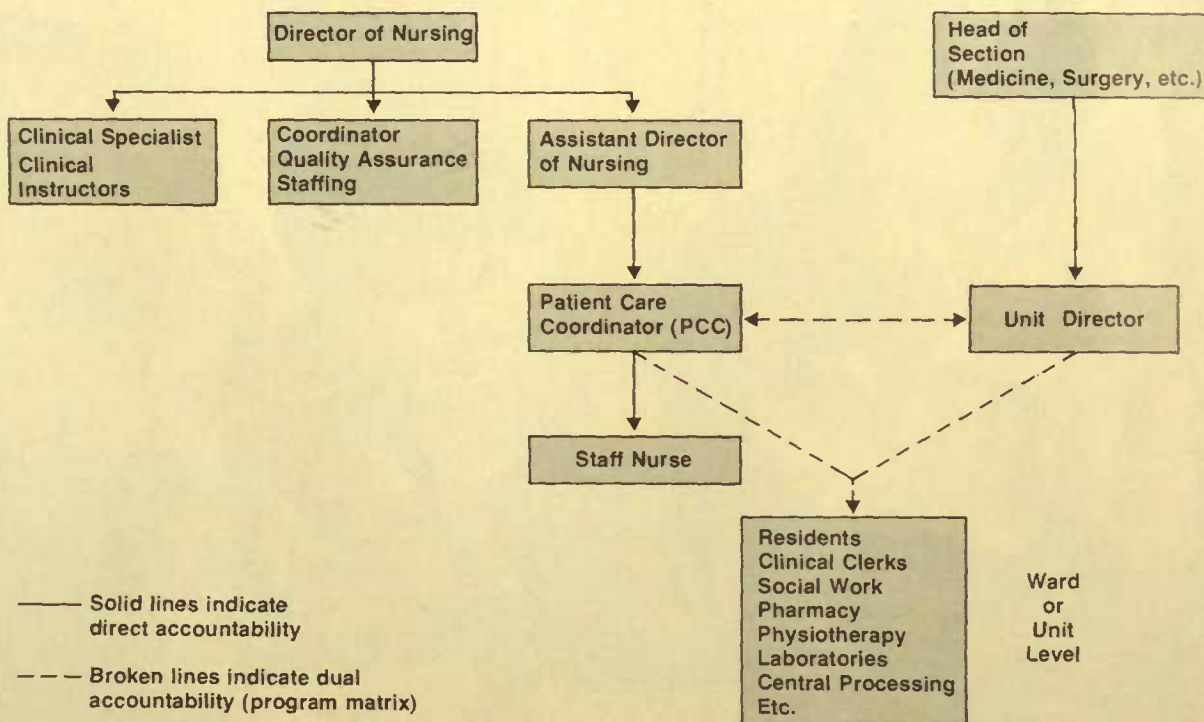
managers, the PCCs are accountable to several individuals in the matrix system, individuals who in turn have a responsibility to them.

Nursing staff

As Figure 2 indicates, PCCs are directly accountable to the **director of nursing services** for the standards of nursing care and for the implementation of policy decisions and management of their units. In turn, the director of nursing services is accountable for the standards of nursing care throughout the hospital and for the total management of resources required to carry out this task. This accountability is based on the philosophy that patient care is a priority and all other activities revolve around this primary consideration. To meet this accountability, the director of nursing services ensures that adequate staff members are hired, ensures that inservice education programs are developed, develops and implements tools for evaluating the effectiveness of nursing care and formulates appropriate policies and procedures. One of her chief skills is the delegation of authority; the extent to which this is done effectively differentiates a decentralized nursing management system from other more traditional ones.

In this system, the director of nursing has a responsibility to the PCCs: to help them identify their learning needs; to provide advice on how to meet these needs; to reinforce with them that they have responsibility to make decisions and that this responsibility is backed up with the

Figure 2 Schematic Organizational Plan: Matrix Organization
McMaster University Medical Centre



necessary authority. To help the PCC in taking on these responsibilities educational programs are developed. Emphasis is placed on self-evaluation, and policies and procedures are compiled to be used as effective management tools.

To assist the director of nursing with policy formulation, policy implementation and planning for change, meetings are held with other key members of nursing service as well as members of other disciplines. It is at these meetings that nursing decisions are made based on current nursing literature reviews, results of research and clinical investigative studies and program planning. Involved in the meetings are the assistant director of nursing, director of continuing education, clinical specialists, and clinical instructors. When input from PCCs on pertinent issues is advisable, a representative of the PCC group is invited to take part in the discussion.

What is the relationship between the PCC and the other members of the nursing department?

In the decentralized model, the **assistant director** assesses the nursing management skills of the PCCs and helps them to develop and improve upon these skills. In this position, the assistant director must be able to decide when to supervise the activities of the individual PCC and when to act as a consultant.

Clinical specialists, prepared at the Master's level and **clinical instructors** prepared at the Baccalaureate level act as role models, teachers and

researchers to complement the role of the PCC. They may assist the PCC in the planning and/or implementation of inservice sessions for staff development.

The role of the **director of continuing education** is more global in scope. She has the educational responsibilities for all hospital staff in addition to nursing. She acts as a consultant for inservice education that affects the entire hospital such as cardiac arrest demonstration; holds in-house workshops for management staff; acts as a career adviser; and allocates funds for education and travel outside of the Medical Centre.

The **quality assurance and staff coordinator** works with the PCCs in two important areas: carrying out nursing audits, (both concurrent and retrospective) and managing the staffing office to provide complementary or float pool staff to the units as needed.

Retrospective nursing audits based on the findings in the chart of a discharged patient are done monthly. A staff member from each unit in the hospital takes part in the retrospective audit activities and provides information about the results to the PCC. The quality assurance and staff coordinator ensures that corrective action as a result of the audit is implemented. Concurrent audits, carried out while the patient is still in hospital, rely on the chart, the patient's verbal comments and staff's

verbal observations. This kind of audit is based on standards that have been formulated by the PCCs under the guidance of the director of nursing services.

Medical Staff

A dual accountability exists between the PCC and the **unit director**. Unit directors are physicians assigned by their head of section to each unit or ward. The PCC is responsible, with the unit director, for providing a milieu suitable for patient care, medical education and clinical research as well as monitoring the activities within the ward to safeguard patients' interests. Together, they work in the management of clinical areas. Specifically, the unit directors are responsible for the enforcement of all rules and regulations approved by the Medical Advisory Committee and for informing the medical staff including residents and interns of these rules.

It is with the unit director that PCCs develop a collaborative relationship to ensure that the patients admitted to the unit receive optimal care. The unit director participates in activities on the unit by: auditing patients' records; making regular rounds; orienting both medical staff and students; conducting reviews of utilization of various services; and by supervising clinical trainees.

Although there are policies and decisions that are made external to the unit, a matrix management system is flexible enough to allow PCCs and unit directors to formulate additional policies to improve the functioning of their clinical units.



PCC going over the admission procedure with a patient.

PCC (back) and team leader conference in preparation for rounds.



Meeting the needs of the PCC

Because the PCC role demands advanced management skills, including budget, staffing and personnel responsibilities, a management program is ongoing at McMaster to help the Patient Care Coordinators develop their potential in these areas. Initially, the controller (in charge of the hospital's accounting department) and the director of nursing services help the PCCs prepare their annual staffing, operating and capital budgets in a step-by-step fashion. The staffing budget is based on data collected from the Patient Classification System. From this information, a baseline for full-time staff needed on the unit is established, a baseline which can be augmented with additional numbers from the nursing float pool depending on patient acuity and census.

The operating budget is based on the previous year's experience. The PCCs are given a total yearly amount of money that they allocate to various accounts. At the end of each pay period, the accounting department supplies the PCC with information on how much has been spent by their unit on salaries, illness, vacations, overtime and part-time staff. Also, they receive monthly reports on how much has been spent in each account for unit supplies, repairs etc. The checks and balances in this budgetary system are supplied by the controller and the director of nursing services who monitor all expenditures. Capital budgets are submitted yearly by the units or wards after the Patient Care Coordinators have consulted with members of the medical



PCC talking with a patient during rounds.

SOLVING PROBLEMS AT THE

Sandra LeFort

Q. How is the role of the PCC different from the traditional head nurse role?

PCC: It was always said that a head nurse has responsibility for her unit. But ... there were always supervisors around, checking up on things and telling her what to do. Here, at McMaster there are no supervisors. We really are responsible 24-hours-a-day for our units. The staff is our own, the unit is our own and there are not many people interfering with decision making.

Q. Can you tell me what total responsibility for your unit entails?

PCC: It means that we do all the hiring and firing of the nursing staff and also participate in the hiring of other members of the health team who will be working on our unit such as the social worker, the child care worker, nutritionist, occupational therapist, physiotherapist. It also means that we are responsible for the annual capital and operating budgets for the unit and for making sure that we're staying within our budget. We're responsible for ongoing education in the unit, and for monitoring research. We are one of the people who must give approval for research to take place on the unit. Together with the unit director, we set standards for the nursing care and medical care delivered on the unit.

Q. That sounds like a lot of responsibility. What does it feel like to have that kind of responsibility 24 hours a day?

PCC: It's O.K. At the beginning though, it was a tremendous headache. But over the years, it has sorted itself out. Now it is rare that I get called at home in the evenings or at night and if I do I know that it is serious. At first, when the hospital opened five years ago, PCCs were called all the time — to provide security for the staff who weren't used to their added responsibility.

Q. What is the set-up of the nursing staff on the unit? Is there a replacement for the traditional assistant head nurse, for example?

PCC: Most of the units have permanent team leaders who assist the PCC in running the unit on a day-to-day basis. Although PCCs are responsible for the unit overall, the permanent T.L. is responsible for the staff working with them, for patient care given, for giving information and feedback to the physicians involved in the care of patients.

They are more clinically oriented and in some ways act more in the role of the traditional head nurse.

Q. Let's say that I'm the charge nurse on evenings on one of your units. All of a sudden, I have two emergencies and three admissions and the staff can't handle it. I need more people. If there is no supervisor, who do I call?

PCC: There is always a PCC on call for all shifts and weekends. He or she is not in the hospital but can be easily reached through a paging system. In situations like that, the PCC can probably handle staffing problems over the phone. Having gone to the staffing office before leaving the hospital, the PCC would have a ward census and the number of staff on each unit and so would have an idea of where help might be available. She can call them and get help sent over to your floor.

Q. How does it feel to be able to hire and fire your staff?

PCC: It is certainly better than having a nurse sent over from personnel office and being told "This is your new nurse." By doing our own interviewing, we see the people who come in. Generally, we have a feeling for who would fit in best ... and who will work well with us and our staff. Besides that, we tend to work harder at solving staff problems when we've done the hiring.

UNIT LEVEL: A TALK WITH PCCs

Q. What about firing staff?

PCC: We cannot independently terminate staff. Initially there are reprimands and other disciplinary measures. Serious problems that could mean someone's job would be considered in consultation with personnel and the director of nursing services.

Q. As Patient Care Coordinators, do you meet regularly as a group to discuss common problems?

PCC: Yes, these meetings serve to allow information sharing, group problem solving and it's also a time when other area heads in the hospital have access to us as a group. They come to the meetings with new information, complaints or suggestions. We also meet individually with area heads from engineering, housekeeping and pharmacy to iron out problems or to make suggestions on how services can be improved.

Also, one PCC is elected or volunteers to represent the PCC group at hospital policy formulation meetings. He or she attempts to represent the PCCs' opinions and to interpret what the impact of any policy decision would have at the clinical level.

Q. Because of the administrative and budgetary work that you do, I have a feeling that patient contact could be extremely minimal and you might lose touch with the patients quite easily. Is this true?

PCC: I'm sure that if someone chose to, it would be possible to have minimal patient contact. But all of us are from traditional settings and we like to and are expected to have contact with the patients. It's one important way of keeping in touch with what is going on at the unit level. Many of us, for example, do weekly rounds with the unit director and then daily rounds with the rest of the team.

Q. What about setting up an annual budget for the unit? Is this an easy or difficult part of your job?

PCC: Initially it was quite difficult. Mastering the terminology can be a problem at first. But after the controller has told you a couple of times that you are overbudgeting, you really get down to business and see where you're at. After a while, it is quite easy.

Q. Do you think that this type of organization tends to make people more aware of how much they are spending?

PCC: Our staff is acutely aware of costs. If the unit is overspending, then we let the staff know by how much and ask for ideas on how to save.

Q. When you first came to the unit, was it hard to fit into the role?

PCC: I think the most difficult part is knowing who to report to. Since most of us are used to working in a hierarchical rather than a matrix organization, it is a little confusing at times to know who you should be relating to in the matrix system. The hardest part, I guess, is just figuring out how this place works because it is so different. For example, if we have a problem relating to nutrition services, let's say, we call the department or area head directly not the assistant director of nursing. And the area head in turn should call us directly if they're having problems on our unit. Sometimes, though, they bypass us. But, the director of nursing services always hands it back to us. What the matrix organization tries to do is to eliminate the third party in communication.

Q. What about the nursing staff you work with? How do they see you in the role of a PCC?

PCC: Initially it was difficult because they wanted to see us as traditional head nurses, but that has changed. Now, they seem to have a very good understanding of the role. They have learned to use the position well. Now, if a PCC gets a call from the ward or unit at home, it's important.

I think the staff have grown with the role themselves — they do a lot more problem solving on their own.

Q. Then the increased responsibility you have as PCCs must be filtered down to the staff nurses so that everybody shares the responsibility.

PCC: That's right and we have to be prepared to back our staff. We have to use our judgment, as well as getting firsthand information in any difference of opinion between nursing staff and others.

Generally though there is a much more collaborative relationship between medicine and nursing here. It surprised me because in other places I worked nurses have to prove themselves. Here people seem to have the attitude that you know what you are doing and that you know what is going on.

Q. Can you explain your relationship with the physician who is the unit director?

PCC: The unit director and the PCC are responsible for the operation of the unit. Together, they are responsible to the head of section of Obs-Gyn, or Surgery etc. for all the patient care on the unit, medical and nursing care as well as social work, physio etc.

Q. Generally is there a good working relationship between the PCC and the unit director?

PCC: Well, there has to be. If it's not, then you find yourself working at cross purposes, the PCC going in one direction and the unit director in the other. That is a very frustrating and confusing situation for everybody.

Conflict happens. The only solution is to sit down, talk about it and solve the problem. It usually works out O.K.

Q. Well, it sounds like the PCC role is great, but there must be some problems inherent in the role?

PCC: The sheer demands of the role can cause problems. Sometimes we can get caught in the "middle", as the people who are supposed to pacify everybody.

But, even with that, it's working well. We like it, the nursing and medical staff like it and the patients like it. As we said, problems get solved at the unit level, where they should be. 4

Patient rounds with physician, PCC (2nd from right) and staff nurses.



staff and other health professionals working on the unit.

Members of the administrative staff supplement the talents of the PCCs by helping them develop visual tools such as graphs so that medical, nursing and other allied professionals are kept aware of how much money is being spent and of the wastage and abuses within the system.

The personnel department helps the PCCs develop their communication skills by holding sessions on how to interview and how to counsel effectively. They also keep the PCCs informed about salary negotiations.

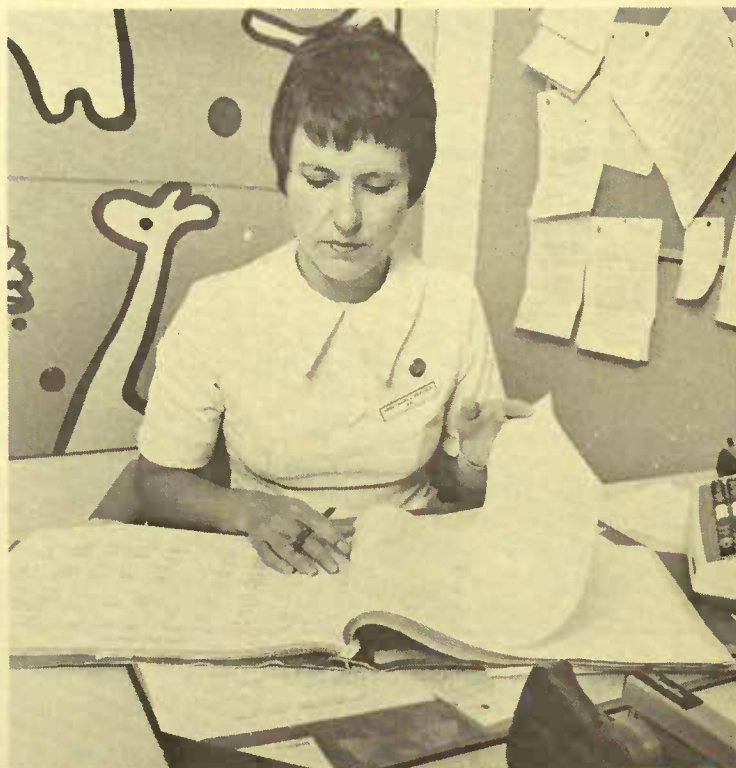
The Patient Care Coordinators meet as a group twice per month; one session is directed to meeting their educational needs and is arranged by the director of continuing education in conjunction with the clinical specialist; the second meeting is used to solve management problems. The agenda for these meetings is prepared by the Patient Care Coordinators and there is a rotating chair.

Involvement and decision making

As PCCs become more familiar and more comfortable with their role at the unit level, more responsibility and change is introduced. Depending on their past experiences as well as their present interest, PCCs are encouraged to be a representative on one of the hospital committees (e.g. infection control, pharmacy, patient care). By taking a more global interest in nursing within the hospital, it is felt that nursing's interest at the hospital committee level will be better represented.



PCC in her role as teacher.



PCC looking over the weekly budget assessment.

Because of the decentralized style of nursing administration at McMaster PCCs, team leaders and staff nurses take part in the development of nursing by serving on various task forces. For example, one task force is developing position descriptions based on the Standards of Nursing Care developed by the College of Nurses of Ontario. Another group is involved in developing an evaluation tool which will provide criteria necessary for professional development and the maintenance of competency; another is designing a data base as a step to implementing predeveloped nursing care plans. In the near future, a group will investigate the pros and cons of implementing primary nursing in medical/surgical units, while another will review the Patient Classification System. Staff nurses and team leaders are encouraged to participate in such committee work including auditing, nursing procedures etc. so that all levels of nursing will be involved in decision making. Also, such multi-level involvement tends to enhance information sharing and behavior change at the unit level.

Only the beginning

PCCs as middle managers are the focal point of the nursing organization at McMaster. With the development of sound managerial techniques and an ability to set priorities, they are the focus for competency, leadership, decision making and problem solving at the unit level. Because the role is a dynamic one, they must commit

themselves to improving their own nursing competency and theory through continuing education, to investing some time in student education and to getting involved in nursing projects throughout the hospital. Exercising total responsibility for their unit is no easy task. Success in implementing this expanded role depends on the commitment of the hospital administration to developing and supporting this group of middle managers.

After five years in operation at McMaster, this combination of head nurse and supervisor has proven to be both viable and challenging. It is a role that enhances direct communication within the hospital, encourages problem solving at the unit level and ultimately results in better patient care. 4

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A staff conference showing the PCC (2nd from left) with her staff.

PICKING UP THE CUES

Mr. Jones "seems anxious." Mrs. Smith "has trouble sleeping." It's easy to hide behind the familiar phrases ... to make subjective, unsubstantiated judgments and to express them in guarded phrases and tentative terms. "Selective ignorance" is how some critics describe it. But how does a nurse go about acquiring the methods and techniques that enable her to make the kind of precise and objective clinical appraisal that can lead to successful nursing intervention?

Suzanne W. Fletcher
Celia S. Oseasohn

One way of helping student nurses to develop their clinical skills in identifying patient needs and problems is to increase their opportunities for "live" problem-solving. With this in mind, the authors — a doctor and a nurse — instituted a joint teaching project at McGill University for registered nurses enrolled in the baccalaureate program. As a result of this nine-month experiment, they are convinced that assisting student nurses to carry out periodic health screening in an ambulatory setting and encouraging them to conduct selective home visits is a feasible approach to teaching assessment skills.

Nor were the students the only ones to gain from the experience for, through their assessments, these student nurses were able to identify new problems for which diagnostic or therapeutic treatment could be initiated in almost all of the patients that they saw.

Specifically the students were taught how to collect clinical information in a systematic way, components of the physical examination, use of laboratory procedures, and methods for home assessment of patients. The method of teaching these skills involved the use of multiphasic screening and home visits and the focus of the project was the identification of new clinical problems in ambulatory patients.

Today, many baccalaureate nursing programs are incorporating physical assessment skills into their undergraduate program.¹⁻⁴ In McGill's baccalaureate program for registered nurses, the course on physical assessment is given throughout the first semester of a two-year program and consists of a two-hour class each week. Videotapes are used as the basis for discussions of the pertinent anatomy, physiology, laboratory tests and techniques needed for each part of the physical examination. These classes are followed by

two-hour practice sessions in which pairs of students examine each other under supervision.

In addition, students spend one day a week in a clinical setting. Since the focus of the course is to recognize deviations from health rather than specific diseases, an ambulatory medical clinic appeared to be a more appropriate instructional setting than an inpatient unit.

The project

Work on the project was carried out between September 1975 and May 1976 in the Royal Victoria Hospital Medical Polyclinic, an ambulatory clinic similar to other teaching hospital outpatient facilities which tend to accumulate elderly chronically ill patients with multiple problems.⁵

The project physician selected ten medical colleagues who worked in the Polyclinic and were members of the attending staff of the Department of Medicine. Most of these physicians are sub-specialists. The nurse instructor assigned two student nurses to each of the ten physicians. Each student telephoned patients selected from her physician's patient list and enrolled the first three patients whom she contacted. These patients were asked to participate in a multiphasic screening examination to be conducted by the nursing student.

The examination included a standard health questionnaire⁶ and the following assessments: blood pressure, height, weight, visual acuity, tonometry, blood leukocyte count, hematocrit, serologic test for syphilis, 16-channel automatic biochemical tests (SMA-16), urine analysis, electrocardiogram, chest X-ray examination, and breast examination and cervical smear in women. Laboratory tests done within six months and electrocardiograms, X-ray examinations, and

cervical smears within one year of the screening were not repeated; previous results were used instead.

When all of these data were gathered, the student prepared a problem list with a suggested plan of action and met with the physician to discuss her findings. A problem was defined as a complaint by the patient, an abnormal physical sign elicited by the nurse, or an abnormal laboratory finding. A problem might be physical, economic, social or family related. Between them, the nurse and physician decided upon the next step: a home visit to assess family interaction or review medications, further laboratory procedures, or referral to a specialty clinic such as ophthalmology.

Meetings between the nurse and physician were scheduled in advance; they lasted approximately 15 minutes, and were oriented towards the management of the newly identified patient problems. In this way, a collegial relationship developed between physician and student nurse.

In addition to customary clinical skills related to the individual, it was decided that the students needed to learn to assess the family and the home environment. Accordingly, forms were developed to help the student make systematic observations about the household, the family, the functional status of the patient, and the drugs found in the home.

Form I seeks data describing living arrangements. Are they adequate for cooking and refrigeration? Is there heat, light, and hot water? How many steps or levels does the patient need to navigate? How readily can one prepare meals, shop for food, clean the house, and do the laundry?

Form II deals with the functional status of the patient: vital signs, orientation, memory, mood, ability to carry out activities of daily living, and socialization.

McGill University
School of Nursing

Form I — Home Visit
LIVING ARRANGEMENTS

Patient Name _____
O.P.D. No. _____
Date _____
Nurse _____
Physician _____

Arrangements	Patient indicates problems		Comments
	Yes	No	
Income (adequacy)			
Housekeeping			
Preparing meals			
Food shopping			
House cleaning			
Doing laundry			
Adequacy of Facilities			
Heat			
Light			
Cooking			
Refrigeration			
Hot Water			
Sleeping			
Toilet			
Residence			
Type			
No. of Steps/Floor			
No. of Family/			
No. of Rooms			

McGill University
School of Nursing

Form II — Home Visit
FUNCTIONAL STATUS

Patient Name _____
O.P.D. No. _____
Date _____
Nurse _____
Physician _____

1) **Vital Signs**

☐ Pulse _____

☐ Blood Pressure _____

2) **Mentation**

	Assessment		Comments
	Normal	Abnormal	
<input type="checkbox"/> Orientation			
<input type="checkbox"/> Memory			
<input type="checkbox"/> Mood			

3) **Activities of Daily Living**

	Yes	No
<input type="checkbox"/> Feeds self		
<input type="checkbox"/> Bathes self		
<input type="checkbox"/> Dresses self		
<input type="checkbox"/> Number of hours/day out of bed		
<input type="checkbox"/> Number of times outside of domicile/week		

Results



Celia S Oseasohn

Suzanne W. Fletcher



Form III itemizes medications taken by the patient, either prescribed or "over the counter" or both. The nurse assessed the patient's ability to identify individual drugs, explain their purpose, and adhere to prescribed dosage schedule. This information was used as a basis for teaching the patient and family.

Findings

Using **Form IV** each student summarized her experience. She listed new problems which she had identified whether the physician concurred what actions ensued.

A total of 54 patients were observed by the students and 58 new problems were observed. Only one patient had no new problem. Physicians agreed with nursing student findings in 38 of the 58 instances and action was initiated in 32 of these 38 cases.

Evaluation

The use of an ambulatory medical clinic facilitated instructional goals that included: development of clinical skills understanding biological variation and its impact on laboratory findings awareness of difficulties in the provision and acceptance of services such as the problem of patient compliance the use of community resources. A particularly useful activity was the joint planning by nurse and physician based on this whole range of inputs.

Certain limitations, however, were encountered in the clinic situation which warrant attention in future instructional planning:

the time needed by students to complete systematic clinical assessments was often in excess of prior estimates

there were limits to the number of procedures which elderly subjects were able to tolerate at any one visit and certain specific procedures such as cervical smears were inherently difficult

collaborating physicians were often not immediately available when problems were encountered by the student with the results that patient's visits were occasionally prolonged or additional appointments required.

in a crowded ambulatory care setting, it was difficult to find the space to carry out this project.

New problems were found in nearly every patient. Physicians usually concurred with the findings, and diagnostic or

therapeutic actions were taken in the majority of instances. Therefore, it appears that this teaching approach, with its focus on identifying new problems, is feasible in this setting and may apply to other settings as well.

Implications

Previous studies have dealt with the role of nurses in ambulatory medical care. Lewis and Resnik,⁷ for example, described the effectiveness of a clinic in which nurses served as the primary source of care for adults with chronic illness. They found that patients in the nurse clinic fared better in terms of reduction in the frequency of complaints and in hospitalizations than a comparison group of patients managed by house officers. There was a decreased tendency to call upon physicians for minor complaints. Patient satisfaction with care given by nurses was high.

Studies such as this raise important questions. Would periodic health screening and selective home visiting by nurses serve to promote health and well-being among elderly chronically ill patients? Would it help to reduce the frequency of hospital, clinic, and emergency room use? These questions merit carefully designed trials. Certainly, the results of this study suggest that periodic health screening and selective home visiting is a feasible approach to teaching nurses assessment skills. ♡

Co-authors Celia S. Oseasohn and Suzanne W. Fletcher are also co-workers at McGill University in Montreal.

Celia Oseasohn, who is associate professor of nursing at McGill, is a graduate of Mt. Sinai Hospital in New York and obtained her B.S. and M.S.N. from Frances Payne Bolton school of nursing, Case-Western Reserve University. Some time ago, she and her husband who is a physician-epidemiologist, with their three children, spent two years in what is now Bangladesh. Her work there and in New Mexico, she says, made her aware of the need for nurses to learn physical assessment skills.

Suzanne Fletcher received her M.D.

from Harvard Medical School and her M.Sc. from Johns Hopkins School of Hygiene and Public Health. A National Health and Welfare Scholar who is interested in health services research, Dr. Fletcher is assistant professor in the Departments of Medicine and Epidemiology and Health, McGill University and a physician at the McGill University Clinic, Royal Victoria Hospital. The mother of two boys, she is married to an internist.

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INFANCY: THE NEGLECTED AGE IN NUTRITION EDUCATION



Do you recall the infant nutrition advice provided by health professionals a few years back? — rigid and dogmatic feeding schedules that left little room for parental thought or error. Those days are thankfully over, but there is evidence that the pendulum has swung so far away from those feeding schedules that new parents are left without any infant feeding advice at all.

Within this laissez-faire climate, a number of controversies have emerged, and many parents just don't have the knowledge to meet them. So maybe it's time for us to help sort out the issues and help parents to understand and meet their baby's nutritional needs.



FACTS FOR CHANGE

Carol Raebiger Sage



The first few days at home with a new baby can be an anxious time for new parents. Naturally, part of this anxiety focuses on feeding, making sure that their baby has enough of the right food. Parents may feel that their adequacy in their new role is being tested as they begin to make new decisions and establish important feeding patterns with their child. They will also be faced with controversies.

Today, there are a number of areas of controversy about infant feeding, areas that require clarification and guidelines if parents are to be confident in their new role and provide the best nutrition for their babies. Some of these issues are: demand feeding, breast feeding, introduction of solid foods, and prevention of obesity in infancy.

As health professionals, our knowledge (or lack of it) in these areas has important implications, for we are in a key position to help parents understand the issues and meet their baby's nutritional needs.

Scientific knowledge about the effects of infant feeding practices is growing, lending us more facts on which to base our teaching. Let's take a look at some of the issues, and at some of the facts behind them.

Demand feeding — how much is enough?

Demand feeding in its truest sense means feeding the baby as frequently and as much as he demands. Difficulties arise with this deceptively simple method because the infant can't simply say "I'm hungry," and later "Stop, I'm satisfied." A mother needs time to develop sensitivity to her baby's actions, so that she can know when he is hungry and when he is satisfied.

Indications that demand feeding is not as easy as it sounds are becoming more frequently reported. For example, Fomon¹ and others are finding that bottle-fed babies are heavier and longer than their breast-fed counterparts. Why? It is suspected that some mothers may be prone to encouraging their babies to "empty the bottle," and that some babies are not adverse to accepting the extra milk.

Often a mother needs help to appreciate the fine line of distinction between feeding her baby the largest volume of milk that he will accept and offering him enough milk to relieve hunger. When in doubt about feeding, many parents tend to err on the side of overfeeding rather than risk not giving enough.

We can provide a valuable service by arming parents with relevant information about infant nutrition, letting them know about:

- the nutrient needs of newborns;
- the food sources for these nutrients (see Table 1);

- how much and how frequently infants are usually fed;
- the unique growth differences of each individual baby. (Problems usually arise when a mother compares her baby with others).

This kind of information can alleviate a good deal of parental anxiety and trial-and-error feeding behavior. It allows parents to relax and enjoy the early days of infancy, confident that they are neither overfeeding nor underfeeding their baby.

TABLE 1

Suggested Guide for Introduction of Solid Foods⁷

Age in Months	Food	Reason for Introduction
1-3	<ul style="list-style-type: none"> • Breast milk plus vitamin D or formula fortified with vitamins C & D 	— meets the infant's nutritive needs until 3 months of age.
3-4	<ul style="list-style-type: none"> • Iron enriched infant cereal 	— provides a dietary source of iron. The infant's iron reserves last only 3 months. Milk is a poor source of iron.
4-5	<ul style="list-style-type: none"> • Pureed vegetables • Pureed fruits 	— provides dietary sources of vitamins, minerals, calories. Introduces new food flavors. Starts setting basis for good eating habits. Introduce vegetables first to reduce the chance of developing a sweet tooth.
6-7	<ul style="list-style-type: none"> • Dried bread • Whole undiluted milk 	— encourages chewing when teeth erupt. — digestive system ready to handle butterfat.
6-8	<ul style="list-style-type: none"> • Pureed meat and alternates (beans, peas, lentils, etc.) • Egg yolks • Cottage cheese 	— provides additional protein, vitamins, iron for rapid growth. Egg white not offered until 12 months to avoid precipitation of allergy.
8	<ul style="list-style-type: none"> • Mashed "family" vegetables • Other mild cheese 	— introduces texture of foods other than pureed.
10	<ul style="list-style-type: none"> • Chewy finger foods 	— encourages chewing, co-ordination, independence.

Breast feeding: theory vs. practice

So many sources admit that human milk is ideally suited to meet the nutritional needs of the newborn — medical and nutrition texts, journal articles, even infant formula companies. In spite of this strong and universal endorsement, however, the numbers of infants in North America receiving human milk are very small.

A recently released report from Nutrition Canada² revealed that only 16 of the 250 infants in the survey were breast-fed. Although this group of infants did not constitute a probability sample, the report seems to indicate that the practice of breast feeding in Canada needs a strong boost.

Looking at American figures: in 1975 Fomon³ conducted a survey of infant feeding practices and found that only 20% of American infants were breast-fed in the first month after birth, and percentages decreased with each succeeding month.

Scientific evidence in favor of the unique features of breast milk is becoming stronger and more compelling; it would appear that the practice *should* be strongly supported by health professionals. But this does not seem to be the case.

Eastman,⁴ for example, surveyed 100 healthy mothers who chose to breast feed their babies. The author found that almost none of them had received any information about breast feeding from professional sources, whether family doctors or prenatal clinic personnel.

If we are really convinced about the superiority of human milk, we must develop a positive method of communicating the facts to would-be parents. Such an effort involves time, time for the parents to review their existing attitudes about breast feeding, time for discussion and examination of the facts. The theory is available to us; as health professionals, we should be providing guidance.

Solid foods — a confused issue

The confusion that exists today about the introduction of solid foods to babies is further evidence that sound nutrition education about infant feeding is sadly lacking.

Jelliffe and Jelliffe⁵ attribute the lack of infant nutrition information to health professionals. They say that since 1940, decision-making responsibility has simply been deferred to parents. In need of some direction, parents seek advice where they can get it — whether from friends, relatives, mass media, or the food industry.

Even when doctors discredit undesirable feeding practices, their advice often goes unheeded by mothers. In 1969, Harris and Chan surveyed⁶ a group of physicians and their pediatric patients. Most of the

physicians involved did not endorse the introduction of cereals before the baby was two or three months old. However, almost 80% of their infant patients were receiving cereal at one month of age or earlier. Apparently the physicians' rationale for not encouraging this practice was not communicated to the mothers involved in a convincing way.

There are several aspects of the solid food issue that spotlight the need for nutrition guidance.

The 'when' of solid foods

Several unproven ideas have received popular acceptance as reasons for early introduction of solid foods to the infant. One suggestion is that offering a wide range of solids in infancy will facilitate later acceptance of these foods. Another is that starting solids early will help the infant sleep through the night sooner. Neither of these claims have been validated in the literature.

A concern with the adequacy of an infant's iron stores has fostered the suggestion to introduce iron-rich cereals by the second month of the baby's life. But the Canadian Pediatric Society recommends that a healthy full-term infant does not need an exogenous source of iron until around four to six months.⁷ In addition, *The Dietary Standard for Canada*⁸ indicates that while breast milk contains less than the recommended 7 mg/day of iron, it is probably better utilized than iron from other sources. So it seems that the urgency surrounding the introduction of dietary sources of iron during the first two months is unfounded, that its introduction at this age is somewhat premature.

What is important is that solid foods be started when there is a physiological basis for them — when the infant has the oral dexterity to handle foods other than milk, and when he requires nutrients that are not provided by milk — that is, at about three to four months of age.

What type of food

It seems that this is an age of experimentation as far as selection of foods for infants is concerned. Three-month-old babies quite commonly receive strained cereals, fruits, vegetables and meat. Parents assume that if their baby eats without the bother of stomach cramps, diarrhea or rashes, he is ready for such food; and so they see no harm in giving it to him. Many times, the baby's acceptance of a variety of foods is seen as proof that he is "advancing well for his age."

This practice may not be as harmless as it seems. It may provide the infant with

excessive caloric intake. Dwyer and Mayer implicate the practice of early introduction of solids with an observed increase in obesity in infants.

Commercial foods vary in their caloric density per unit volume. During the early months the infant is geared to thrive on the caloric concentration found in breast milk or formula (65-67 calories /100 ml). Many infant foods have a greater caloric content per unit volume than milk, for example — cereals, meats, some meat dinners and desserts.

Are these foods being used as a replacement for part of the volume of milk already consumed by the infant or in addition to the established volume of milk? Many parents fail to grasp these distinctions. If food is used to replace part of the volume of milk, perhaps the child isn't receiving the valuable nutrients provided by the milk (and absent in baby food). For example, the child might receive less protein and calcium than he needs, because these are not abundant in cereals, fruits and vegetables.

On the other hand, if the child receives food on top of the established volume of milk, he might be overfed. It is important therefore that parents understand the nutrient content of milk and baby food.

The infant under four months also faces a metabolic overload to his immature system when substantial quantities of solid foods are introduced. His body has to process and excrete the metabolic end-products of the additional protein, sodium and other electrolytes present in solid foods. He will have greater fluid requirements in order to produce a greater amount of urine — and if additional water is not offered, he will be thirsty. He may cry because of thirst, but his actions may be interpreted by parents as signs of hunger. If he is offered milk, he has another caloric load to deal with, and more nutrients contributing to the renal solute load rather than alleviating it.¹⁰





Commercial foods or home prepared?

Another dilemma involved in the solid food issue lies in the decision to use commercial baby foods or home prepared ones. It is obvious that many working mothers simply don't have the time to process all of their baby's solid foods. But with adequate nutrition guidance mothers can venture into the supermarket with its 400 varieties of baby food and select those products that offer nutritional value as well as convenience.

Home preparation of baby foods is gaining popularity today. Parents need to be advised of proper handling and preparation techniques to ensure the safety and nutritional quality of home prepared products.

Both commercial formulas and baby foods are relatively expensive, hard on the budget. Dwyer and Mayer¹¹ call attention to the fact that the baby may be overfed because mothers are trying to avoid wastage by adopting a "clean plate principle." Practical suggestions on ways to handle leftover foods so that they retain their nutrient content and remain safe are a help in ensuring that the mother won't feel pressured into making her infant a human food disposal.¹²

As you can see, there are a number of educational areas that we must consider regarding the introduction of solid foods to an infant. Parents need guidance in order to examine and explore these areas so that they can apply their knowledge to feeding their baby.

Prevention of obesity in infancy

Currently, a good deal of attention is being paid to the prevention of obesity through calorie control in infancy. It should be noted however that popular solutions to the fat baby problem may just be a bandaid treatment; certainly, they bear some examination.

Endorsement of the use of skim milk is one of these superficial solutions to the fat problem. But studies are showing that it isn't the best solution. Fomon¹³ compared the effects of the use of a skim milk formula with a standard formula on four to six-month-old

infants for a period of eight weeks. This study indicates that the skim milk group consumed a larger volume of formula containing fewer calories than the control group. The skim milk babies had a sharp decrease in skin fold thickness.

It is assumed that these fat stores were utilized for growth purposes. But depletion of normal fat stores could compromise the ability of some infants to withstand prolonged serious illness. Another hypothesized risk for the skim milk baby is that the consumption of larger volumes of milk will develop a blunted satiety mechanism, that the infant will associate "overstuffed" with "satisfaction of hunger."

Another popular preventive measure for obesity is weaning the infant from breast milk or formula to 2% milk. Since weaning is viewed as a milestone, many infants are encouraged to make this conversion long before the recommended six months of age. The choice of 2% milk is viewed in some circles as desirable because it provides only half the fat content of whole milk. However, there are serious questions being raised about its use for the young infant.

Spady¹⁴ provides comparisons between human milk, formulas, whole cow's milk and 2% milk. It becomes quickly apparent that 2% milk provides the young infant with excessive sodium, potassium, calcium, phosphorus and protein, thus seriously increasing the renal solute load. With these concerns about 2% milk, it is obvious that skim milk is even less acceptable.

If parents really understood their baby's nutritional needs, there would be no necessity to seek out superficial solutions. It is most important for us to help parents avoid overfeeding their baby.

Our role is to help them to understand the real cause of the obesity problem ... too much food? too much milk? ... too little stimulation and exercise? From this understanding, it is possible to select an appropriate corrective measure instead of seeking out inadequate, non-specific and potentially harmful cures.

In discussing each one of these controversies, one thing becomes evident: there is no substitute for sound nutrition education. Having shed some light on areas of confusion, and the important role we have in teaching parents, let's take a look at how we can make our teaching effective. ♣

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reviewing the article and adding their suggestions and recommendations.



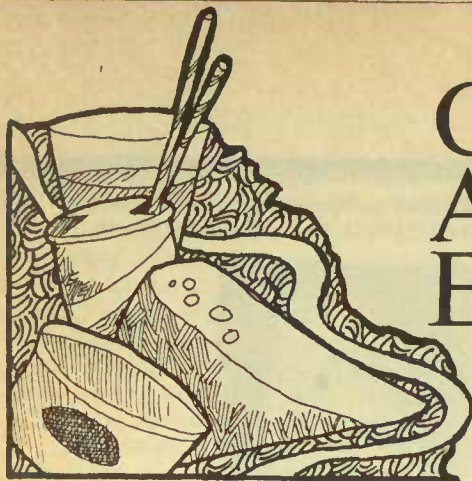
Carol Raebiger Sage (B.S. in Dietetics from Drexel University, Philadelphia, M.S. in Public Health Nutrition, Case Western Reserve University, Cleveland, Ohio) has spent three years as a dietitian in the United States Air Force, and has acted as Nutrition Consultant with the Wisconsin Division of Health and the Ontario Ministry of Health.

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CREATING A LEARNING ENVIRONMENT



Deborah Chute



As health educators, we have a key role to play if recommended infant feeding concepts are to reach those who need them most — the parents-to-be of today's youngest citizens.

The body of scientific knowledge about infant nutrition has grown rapidly in the last few years. Health professionals now have more facts or strong indications as a basis for their recommendations regarding desirable infant feeding practices.¹ It is time for us to take a leadership role in transmitting this information to parents in a convincing way.

Because we are educating adults, it is helpful for us to keep in mind some of the concepts of adult education. Pine and Horne remind us of two major learning principles. Let's take a look at these principles before we tackle the problem of effective infant nutrition education.

- "Learning is an experience which occurs inside the learner and is activated by the learner."²

The process is primarily controlled by the learner, and we must remember that it does not occur by some magic transmission from the teacher. What then is our role as teacher? Our function is to create a learning environment, one that motivates the learner to use the subject matter being examined. Just presenting facts — for example, using lectures — is not always the most effective way to accomplish this goal.

- "Learning is the discovery of personal meaning and relevance of ideas."³

People are more likely to implement new concepts if they are relevant to their immediate needs and problems.

Let's consider now how these general learning concepts may be incorporated into infant feeding education programs for parents — in the prenatal months, during the hospital stay, and after their return home. These are critical periods, when parents have a readiness to learn about the subject. Specifically, let's look at what kinds of questions express the immediate concerns

about infant feeding during these periods and how we as educators can help parents discover the answers to their concerns.

The prenatal period

The first period of readiness appears to be during pregnancy. Eastham⁴ and fellow workers concluded from interviews with 100 breast-feeding mothers and 100 bottle-feeding mothers that much more effective educational approaches are needed. The prenatal period is cited as a critical one to allow parents time to reach the right feeding choice for themselves and for their babies.

WHAT?

From the results of the Eastham study, we can speculate on some of the concerns that face parents-to-be as they attempt to decide if breast feeding is right for them and their baby.

- What are the health benefits of breast feeding for my baby?
 - Will my husband be supportive of a decision to breast feed?
 - Will I be able to supply enough milk for my baby's needs?
 - Will I be embarrassed to breast feed?
 - Will breast feeding affect my figure?
 - Will it restrict my social life too much?
- All of these concerns can be used as subject matter for educational programs during the prenatal period.

HOW?

Adults never enter a learning situation as clean slates. Their present knowledge and attitudes are greatly affected by their past experience in life. Attitudes about breast feeding for example, will be influenced by past exposure (or perhaps lack of exposure) to breast feeding.

In a discussion about education for adults, Knowles⁵ reminds us that "we adults are very jealous of the worth of our experiences and whenever we find people

devaluing our experience, not paying attention to it, not incorporating it in the educational plan, we feel rejected as people." Our role as educators in infant nutrition is to set up the learning environment in a way that allows parents to express their experiences and concerns.

Small group buzz sessions during prenatal classes can be a useful teaching technique to help create such a learning environment. They can be used to encourage the active participation of parents in a discussion of personal feelings and attitudes.

For example, ask groups of two couples to discuss what they feel are the advantages and disadvantages of breast feeding. Then have the ideas from these small group buzz sessions shared with the total group. In the ensuing discussion, several things will become obvious: the present knowledge level of parents; what they see as the strong points of breast feeding; and what aspects make them uncomfortable. Further discussion and fact-giving can be planned around the concerns expressed and the knowledge gap evident in the group.

The prenatal period offers the teacher an excellent opportunity to help parents examine their own attitudes towards food. What foods do they like? dislike? Do they tend to be picky eaters? to overeat? Is eating seen as an emotional outlet? a relief from stress? Reason alone hardly ever determines eating habits. But given the chance to understand themselves and their lifestyles in relation to their eating habits puts parents in a better position to consciously develop eating patterns they will be proud to pass on to a new family member.

Rand⁶ discusses a teaching technique designed to help parents explore how emotional associations with food develop in infants and children. Words that convey food attitudes are placed in a spiral around a picture of an infant. Parents are asked to give everyday examples of how food takes on such meaning. For example, food becomes a *pacifier* if every time a child cries, he is given food whether or not his cry arises

from hunger. Or, food is given as a *reward* for accomplishment or good behavior.

(Unfortunately, sweets are frequently used as a food reward). Other food meanings are security, experimentation, weapon, love, comforter, crutch, fear, creativity, and so on.

Group discussions can then center on:

- Which of these meanings have a positive (negative) influence on good food habits?
- Which of these influences are having an impact on the parents' present eating habits?
- What can parents do to plan for a positive influence on their baby's food attitudes?

Learning is an evolutionary rather than a revolutionary process.⁷ It requires time and patience. It can be a painful process when, for example, the learner recognizes the need for behavioral change, for giving up old and comfortable ways of thinking and acting. That is why it is so important to discuss food attitude changes before a baby's arrival. The parents need help to come to grips with their own attitudes and time to make some changes gradually.

During the hospital stay

The second period of receptivity to new information is during the hospital stay following delivery. Although a mother is in the hospital a very short period of time, she will be looking for as much assistance as possible to help her handle her immediate feeding problems with the new baby.

When Eastham investigated the reasons for early cessation of breast feeding, it was concluded that those opting for breast feeding needed better technical information and support.⁸ While education is needed during the prenatal period, the role played by the maternity ward staff is critical in the initiation of successful breast feeding. What better time to assist the mother in the techniques of nursing than when she first starts to feed her newborn?

WHAT?

What kind of education is offered on the maternity ward of your local hospital? A team of the dietitian/nutritionist and the nurse can together provide some valuable educational sessions on an informal or formal basis here. Are opportunities arranged for mothers to meet with the nutritionist and the nurse or nursing student to discuss immediate feeding concerns?

If a mother is breast feeding, she may be wondering:

- What are the best techniques for breast feeding?
- How can I be sure my baby is getting enough milk?
- Will my food habits affect my milk supply?⁹

Taggart¹⁰ summarizes the technical advice necessary for successful breast feeding. She outlines knowledge appropriate for educational programs on breast feeding for each stage in the maternity cycle — prenatal, in-hospital, and at home.

Formula-feeding mothers are equally in need of adequate technical advice. Some of their concerns may be:

- How do I prepare the formula?
- How can I be sure I'm not overfeeding or underfeeding my baby?

In addition to the topics previously mentioned, mothers will appreciate guidance on such issues as the use of vitamin supplements and when to add baby cereal.

HOW?

A simple case study given in a small group setting is often an effective way to stimulate mothers to think ahead to some of the problems they may face after they go home and what resources are available to help them.

Consider this example. "A new mother is home from hospital for two weeks. The baby is still crying for a feeding about every two hours. Is this normal?" The ensuing discussion could then center around such issues as:

- the normal frequency of feeding for newborns
- the law of supply and demand in breast feeding;

Davis¹¹ feels that a common reason for early cessation of breast feeding is related to a mother's fear that her milk production is inadequate; quite naturally the mother adds unnecessary milk formula or solids.

- a mother's food needs in relation to breast feeding¹²;

A mother may be concerned about the quality and quantity of her breast milk. She may need to be reminded that feeding of solids or vitamin supplements can be unnecessary extras in the early months (See Table 2).

- community resource persons available for help besides the family physician; *Parents need to know about the availability of public health home visitation programs and public health nutritionist.*
- reliable resource books to read; *Parents must be made aware of the vast amounts of unreliable nutrition literature in books, magazines and newspapers. Selective reading is the key. Parents need definite guidance here. If you have captured their interest, you can be sure they will be open to reading more. Leave them with some reliable references.*^{13 14}

In-hospital formula preparation demonstrations offer another opportunity to encourage mothers to become actively involved in learning about a baby's nutritional needs. Ask mothers to read infant formula labels for proper formula preparation techniques and nutritional information. Using the label information and the educator as a resource, the mothers should be able to offer some of their own solutions to such problems as:

- how to prevent overconcentration of formula;
- how to determine vitamin and mineral supplementation needs;
- why solids are unnecessary for at least 3 to 4 months of age.





TABLE 2

VITAMIN SUPPLEMENTATION GUIDE¹⁹

	A	C	D	Fluoride	Other
Human	—	—	X	*	—
Commercial Formula	—	—	—	*	—
Whole Cow Milk Formula	—	X	—	*	—
Evaporated Milk Formula	—	—	—	*	—
Goat Milk Formula	—	X	X	*	Folic Acid

X — supplement needed

* — desirable where water supply is not fluoridated



At home

Many questions are uncovered during the postnatal period when parents are soloing with their new infant. It is difficult for parents to anticipate these concerns during earlier educational experiences. It is also unrealistic to expect them to be able to learn all they will need to know about feeding their baby in prenatal classes or during a short hospital stay.

WHAT?

What is being taught during home visitation or postnatal classes? New parents face many questions that require their decisions during the first weeks and months of their baby's life. Some of these questions may be:

- How long should we keep our baby on formula or breast milk?
- What kind of milk should we use after weaning? homo, 2%, skim?
- Shall we buy baby food, or make our own?
- Where can we get reliable information on this subject?
- The grocery store is a maze of different kinds of baby foods. How do we know which are the best nutritional choices for our money?
- We don't want our baby to be too fat or too thin. How much should we feed him? How often?
- How can we encourage our baby to like a wide variety of foods?

These concerns give us excellent clues to subject matter for learning experiences during this period.

HOW?

There are many exciting and stimulating teaching methods available to us for handling the above concerns.

Adult learning is frequently enhanced in a cooperative situation that applies a "two heads are better than one" philosophy¹⁵. Group curiosity and interest can be stimulated by the educator, who asks a series of pertinent

questions about a common problem. The group can be encouraged to search for and develop rules and principles that seem to apply to the problem situation.

How can this learning technique be applied of the infant feeding situation? A group of parents can be presented with examples of commercial baby foods. They are then asked to decide which products they feel offer the greatest nutritional value for the price asked.

Reading labels provides them with a guide to nutritional content. Included in the comparison could be such products as:

- plain infant cereal vs. infant cereal with fruit added;
- plain strained fruits vs. fruit desserts;
- unsweetened frozen juices vs. canned sweetened baby juices.

Simply reading the label allows parents to identify the amount of unnecessary ingredients in the product e.g. sugar, starch, salt. This discovery can lead to the development of general guidelines for purchasing baby foods with the greatest food value and the least amount of unnecessary ingredients. (See Table 3)

Cooperative learning experiences like this encourage people to be active participants in the learning process. Discovering some of their own answers to a problem adds personal meaning to the new facts and ideas learned.

Word associations provide another means for encouraging parents to participate openly in discussion. Words like "infant cereal," "skim milk," vitamin drops," "fat baby," or "commercial baby foods" help to elicit group response. This response gives the group leader an opportunity to clarify misunderstandings where necessary.

Money is an important issue in infant nutrition. The high cost of food is a powerful incentive governing the parents' choice of infant foods. Cost does not always equate with quality. Parents will be delighted to know the amount of money they can save by preparing their own baby foods or by eliminating the

purchase of unnecessary foods.¹⁶ For example, canned infant juices are not necessary; frozen or fresh unsweetened juices used by the rest of the family are quite sufficient for an infant.

Parents will need help in handling the conflict of economics when it interferes with what is best for their baby. Saving money by eliminating the purchase of baby foods during the first three to four months is to be commended, but saving by going off formula too early is to be discouraged. Those extra few pennies daily to buy formula for at least the first six months of life give an infant the best nutritional balance. They are worth it.

What about those interested in natural foods and home gardening? Those who wish to prepare their own baby foods are looking for tips on how to do it safely and nutritiously.¹⁷

There is currently a great deal of concern about the quality of manufactured baby foods. Guidance for selecting the best nutritional buys among the myriad of baby products available will be wholeheartedly welcomed. (Table 3).

Other critical periods

Eastham¹⁸ found that many mothers felt they had made their choice of breast or bottle feeding even before they became pregnant. The study also found that the husband's attitude has a major influence on a mother's decision to breast feed. Education to effect a positive attitude to breast feeding may well need to begin early in adolescent years and include boys as well as girls.

TABLE 3

When using commercially prepared baby foods, always avoid:²⁰

- those that list sugar as a major ingredient (eg. desserts, puddings).
- special products for infants when the one used for the family would suffice (eg. use frozen unsweetened concentrated fruit juices instead of canned baby juices).
- unnecessary additives (eg. use plain vegetables rather than creamed vegetables).
- dinners: Buy plain meats, vegetables, and fruit.



Family studies units on child care, health classes on nutrition and growth, studies of the sociology and psychology of Canadian eating habits, are some of the areas of school studies where this could effectively be done.

One final word about the coordinated community education effort suggested in this article. We have stated before that learning is an evolutionary process. It requires time. Generally it may be said that nothing absolutely new is ever learned effectively with one exposure. Through repetition, learning is reinforced and made more enduring. However, if hospital education programs are offering different facts from those supplied during home visitation, postnatal, and school classes, only confusion is the result. To ensure that repetition of the nutrition message is consistent, cooperation between school, prenatal, in-hospital and at-home educators is a must.

In summary, we can see that all three phases of infant feeding education for adults — prenatal, in-hospital, and at home — offer natural opportunities to facilitate parental learning. Whether we are involved in group or individual counseling sessions, the success or failure of our educational efforts may well depend on how well we create an atmosphere which enhances adult learning.

Acknowledgment

I would like to thank Carol Raebiger Sage for her help in the development of this article. Acknowledgment is also due to nutritionists Patricia Latner, Catherine Rand, and Sheila Dubois; public health nurses Jill Austin, Miriam Scharf, Muriel Wilson; and associate medical officer of health Dr. R. Williams of the Ministry of Health, for their suggestions in reviewing this article.

Deborah Chute received a B.Sc. in Home Economics from Mount St. Vincent University in Halifax. She worked as Professional Dietitian in the Nova Scotia Hospital in Dartmouth for a year and then taught nutrition to boys and girls for three years at Clayton Park Junior High School in Halifax, Nova Scotia. She also conducted a pilot project to provide home economics education to boys. Deborah returned to the University of Toronto to complete post-graduate studies in Public Health Nutrition. Presently, she works as Community Nutritionist for Niagara Regional Health Unit.

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* References not verified by CNA Library.



Calendar

January, 1978

Jackie Barber Seminars. A series of seminars sponsored by the Continuing Education Department of Health Sciences, The Georgian College of Applied Arts and Technology, Orillia, Ontario.

Working with families — Jan. 25, Huntsville;

Group dynamics and leadership — Feb. 15, Collingwood; *Interviewing techniques* — March 1, Bracebridge; *The helping relationships* — March 15, Midland;

Interviewing techniques — April 5, Orangeville;

Motivating personnel — April 19, Barrie;

Improving communications in hospitals and clinics — May 10, Markdale;

Conflict and change in the professional work setting — May 31, Owen Sound.

Contact: *Continuing Education, Health Sciences Division, 43 Colbourne St. West, Orillia, Ontario. L3V 2Y5.*

February

Day programs in continuing education for nurses sponsored by the Faculty of Nursing, University of Toronto.

Illustrate your message on Feb. 1, 1978. Fee: \$15.

Evaluations are for growing on Feb. 8. Fee: \$25.

Supervision in nursing on Feb. 13-15. Fee: \$125.

Nursing Process in Mental Health and Psychiatric Nursing on Feb.

15-17. Fee: \$125. Contact: *Dorothy Miles, Director, Continuing Education Programme, Faculty of Nursing, University of Toronto, 50 St. George St., Toronto, Ontario. M5S 1A1.*

Share and Care: Rehabilitation of the Ostomy Patient. A two-day seminar to be held on Feb. 2-3, 1978 in Vancouver, B.C. Presented by the British Columbia Enterostomal Therapy Group, the seminar is designed for registered nurses.

Contact: *Gail Hodgkins, R.N., E.T. Enterostomal Therapy, Heather Pavilion "C" Floor, Vancouver General Hospital, 855 West 12th Avenue, Vancouver, B.C. V5Z 1M9.*

POGO-Pediatrics, Obstetrics and Gynecology. A two-day workshop to be held in Regina on Feb. 23-25, 1978. Contact: *Donna Barber, Co-ordinator of Continuing Medical and Nursing Education, Plains Health Centre, 4500 Wascana Parkway, Regina, Sask., S4S 5W9.*

March

Nursing Care of the Trauma Patient. A two-day program to be held in Longueuil, Quebec on March 1, 2, 1978. Fee: \$30. Register by Feb. 1, Contact: *The Order of Nurses of Quebec, Department of Professional Education, 4200 Dorchester Blvd. West, Montreal Quebec, H3Z 1V4.*

Nurse Practitioner Conference. A two-day workshop to be held at the Ramada Inn Hotel in Toronto, Ont. on March 9-10, 1978. Fee: \$20. Contact: *Shirley Wilcox, Community Health Centre, 19 Belshaw Place, Toronto, Ont. M5A 3H6. (416-364-2261).*

Assessment of the Human Aging Process A four-day workshop to be held on March 6-10 in Toronto. Fee: \$50. Contact: *Dorothy Miles, Director, Continuing Education Programme, Faculty of Nursing, University of Toronto, 50 St. George St., Toronto, Ontario. M5S 1A1.*

19th Annual Refresher Course: Issues in Community Health sponsored by the division of Community Health, Faculty of Medicine, University of Toronto. To be held March 6-9, 1978 in Toronto. Contact: *Grace Batchelor, Coordinator of Continuing Education in Community Health, Room 124, Fitzgerald Building, University of Toronto, Toronto, Ont., M5S 1A1.*

Clinical Biofeedback: A seminar for nurses. A one-day seminar to be held on March 24, 1978. Fee: \$20. Contact: *M. Leslea Anderson, Chedoke Hospital, Box 590, Hamilton, Ontario, L8N 3L6.*

April

Cardio-pulmonary Review Course for Critical Care Nurses to be held April 3-6, 1978 and April 10-13, 1978 in Longueuil, Quebec. Fee: \$120. Register by March 3, 1978. Contact: *The Order of Nurses of Quebec, Department of Professional Education, 4200 Dorchester Blvd. West, Montreal, Quebec, H3Z 1V4.*

Genetics for Nurses. A two-day workshop to be held in Toronto on April 10-11. Fee: \$50. Contact: *Dorothy Miles, Director, Continuing Education Programme, Faculty of Nursing, University of Toronto, 50 St. George St., Toronto, Ontario. M5S 1A1.*

May

Alberta Association of Registered Nurses 1978 Convention to be held on May 2-5, 1978 in Edmonton, Alta. Contact: *AARN, 10256-112th Street, Edmonton, Alta. T5K 1M6.*

Cardiology '78. Fifth Annual Seminar on Intensive Care. To be held in Toronto on May 23-25, 1978. Pre-Cardiology '78 Workshop with Dr. Leo Schamroth presenting concepts of ECG and arrhythmia interpretation to be held on May 22-23. Sponsored by the Health Sciences Division, Humber College. Contact: *Conference and Seminar Services, Humber College of Applied Arts and Technology, P.O. Box 1900, Rexdale, Ontario, M9W 5L7.*



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Names and Faces

CNJ talks to... Canada's new PNO

From outpost nurse in northern Ontario to Principal Nursing Officer, Health and Welfare Canada is a big leap but one which **M. Josephine Flaherty** has managed to make with grace, conviction and a sense of purpose.

Appointed to the PNO position in July, Jo Flaherty is just now beginning to settle into her new role, a role that is quite different from her previous position as Dean of the Faculty of Nursing at London's University of Western Ontario.



The Principal Nursing Officer represents nursing's interests, both national and international at the federal government level.

The groundwork for the position was laid in the 1940's by Dorothy Percy who was Canada's chief nursing consultant to the Department of Health and Welfare until 1967. The first Principal Nursing Officer was Verna Huffman-Splane in 1968 followed by Huguette Labelle.

As PNO, Jo Flaherty is responsible for becoming aware of what is happening in nursing by communicating with all the various nursing bodies and agencies and by keeping in contact with other health

care groups to see where "nursing is at" in Canada. To this end, she will be working closely with the Canadian Nurses Association.

As well, she acts in an advisory capacity to the deputy minister keeping him informed on matters relating to nursing and health. In her words, "An important part of my role is to find out what people in our profession are thinking and then to pass on this information."

As well as working within Canada, she will be involved with nursing in other countries, primarily in an information-sharing capacity. This international role is not new to Jo. In 1975-6 she was involved in a Cuba-Canada nurse exchange and continues to provide liaison with the University of Havana.

In her career as a nurse and as an educator, Jo Flaherty has been vocal on many issues that concern nursing. In a recent CNJ interview she expressed her vision of the past and the future of nursing. This is what she had to say.

On the past:

"The history of nursing in this country is outstanding. Canadian nurses have always been well educated and well respected everywhere in the world. In contrast to some countries, we never had a "Dark Ages" in nursing. It has always been an honorable profession. I think that the influence of the religious in early Canada had a great deal to do with this."

On education:

"I don't think you can teach a practice discipline if you do not practice. One big problem is that universities and schools of nursing don't have the budgets to allow for this. Some other health professions are able to blend practice and teaching. I think that if nursing wants to remain viable, nurse educators must practice."

On research:

"Nurses in Canada must get serious about nursing research. We'll never change the face of the health care system until we recognize this. The greatest need right now is for research in nursing practice and to me, this means that the needs have to be

identified by practising nurses. They have to be involved to help the researchers ask the right questions.

"Nursing research is a legitimate concern and discipline but so far we don't have doctoral programs in nursing in Canada. I think that nursing in this country is ready for one."

On the future:

"I think nursing is going onward and upward. This society is focusing on the health status of Canadians and the scope of nursing is that of health care in the broad sense as opposed to strictly illness care.

"I don't buy the division of health and illness on a continuum. We all exist in a state of health that varies according to the factors that change our health status. Nursing is a caring profession that supports the individual's ability to function, that is cope in a healthful manner. The work of nursing is to help people attain, retain and regain health. We are concerned with man's health seeking and coping behaviors. This is the direction in which nursing is going."

Jo Flaherty has been deeply involved with professional nursing since her graduation from the University of Toronto's School of Nursing in 1956. She was president of the RAO in 1971-73 and a member of the CNA board of directors. She was also on the board of directors of the Canadian Nurses Foundation and is a director of the U.S. National Center for Nursing Ethics as well as being a member of many other nursing and education associations.

She is keenly interested in education having completed a Ph.D. in Statistics and Measurement in Education in 1968. She confides that one of her great loves is history and she would like one day to write a history of nursing in Canada.

The School of Nursing, Lakehead University in Thunder Bay, Ontario has announced the following new faculty appointments;

Glenna C. Knutson (B.Sc.N., Lakehead University) as lecturer;
Sandra L. Summers (R.N. B.Sc.N., Lakehead University) as lecturer;
Lorne McDougall (B.Sc.N., B.A., Lakehead University) as lecturer.

Two senior professional staff have been attached to the national office of the Victorian Order of Nurses for Canada.



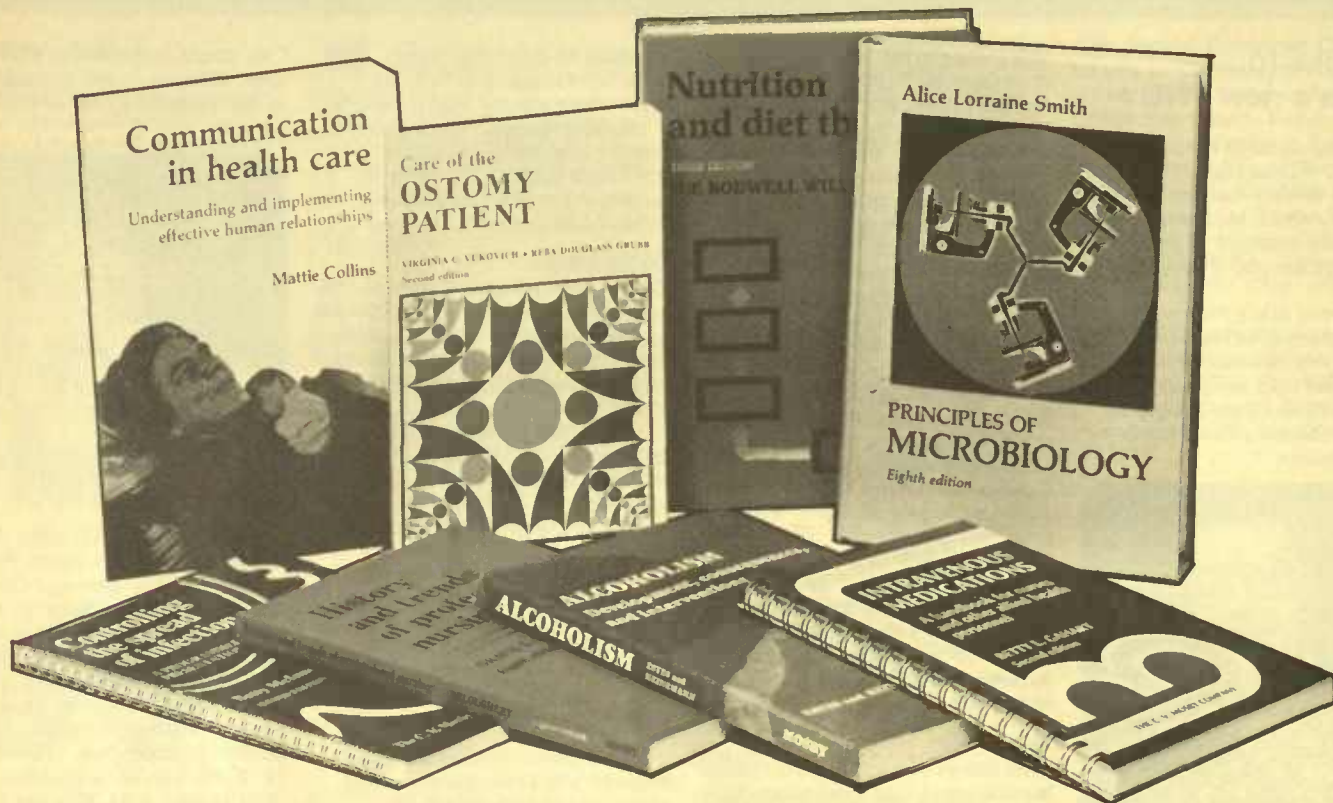
Ruth Mellor has been named regional director for Ontario. She is a graduate of the Montreal General Hospital School of Nursing, and holds a B.N. degree in administration and supervision in public health nursing from McGill University. She began her VON career as a staff nurse in Montreal, later assuming the position of supervisor. From 1971 to 1975 she was district director of the VON London - St. Thomas branch and for the last two years has been regional director for New Brunswick.



Mellor has been succeeded in that post by **Ann Henderson**, who obtained her diploma in public health nursing from Queen's University in 1960, and a B.N. in administration and supervision from McGill University in 1970. Joining the VON in 1960, she has served in staff nurse and nurse-in-charge positions, and since 1970 has been in charge of the Simcoe County Branch.

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- concludes each chapter with a vocabulary list and selected study questions.

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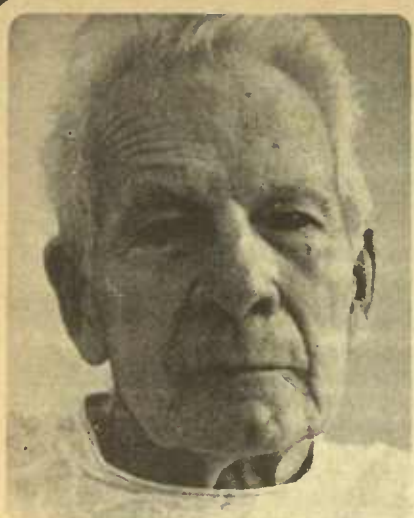
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Books

Interacting with Dying Patients; an inter-hospital nursing research and nursing education project by Geraldine Padilla, Veronica Baker and Vikki Dolan. 219 pages, Duarte, California, City of Hope National Medical Center, 1975.

Approximate price \$7.00

Reviewed by Ann Richmond, staff nurse, Vancouver General Hospital, Vancouver, British Columbia.

This book is addressed to nurses and other health team staff development personnel in hospital settings, those who are concerned with using or developing education programs to improve the care of dying patients and their families. The focus of the text is upon the planned change of attitudes and behaviors which are characteristic of nurses in their interactions with dying patients. The very real need for change is made apparent in the first chapter and emphasized by a brief review of the literature.

The following two chapters present and explain the authors' "Attitude Behavior Change Program" or ABC program. The latter part of the book reports on research designs and on three studies which were employed to evaluate the effectiveness of the ABC education program tested through each study.

The authors provide a rational and a conceptual framework as well as behavioral objectives, content, and detailed methodology for the implementation of their ABC education plan. The plan is explained in detail with a heavy emphasis on a variety of learning tools and guided experiences.

Lacking in the ABC plan are the physical aspects of care that go hand in hand with communication skills. The authors have chosen not to include physical nursing care and I feel that the learner may find it difficult to integrate his communication development in a task oriented environment.

A large portion of *Interacting with Dying Patients* is devoted to the author's actual research plan which is explained in detail along with statistical findings, the measures used to evaluate the effectiveness of the ABC program, and implications for further research and for education. Included is a glossary of research terms as well as the more esoteric details characteristic of a well-planned and tested study. For those who find statistics and graphs dull or impossible to understand, the authors have interpreted their inferences and conclusions in a most readable fashion. They have done an excellent job of explaining. For example they reinforce the meaning and importance of the independent variable from time to time — a helpful reminder even for those familiar with statistical jargon and a godsend for the rest of us.

The book includes literature and references given to those who have taken the ABC program. It offers a multitude of suggestions for revision and adaptation of the material and stresses the need for follow-up and support for nurses who are developing their skills in working with dying patients. The authors have done more than attempt to inspire the reader to provide terminally ill people with more appropriate care. They have given to all of us the fruit of their labors — a well organized and most humanistic tool, the Attitude Behavior Change Program.

General surgery for nurses by Harold Ellis and Christopher Wastell. London, Blackwell Scientific Pub., 1976.

Approximate price \$14.75

Reviewed by Kit Jones, Teacher, Nursing Department, Ryerson Polytechnical Institute, Toronto, Ontario.

This text summarizes common conditions requiring surgical intervention, with brief explanations of:

- the anatomy and physiology of relevant systems;
- organs or groups of organs;
- the signs and symptoms of the related pathology;
- consideration of factors for establishment of a differential diagnosis;
- basic medical management;
- surgical procedures and complications.

Geared to "nurses in training," the authors include introductory chapters on infections, shock, burns, tumors, and the care of the surgical patient.

Most of these topics are covered briefly and succinctly. Of particular value is the section on shock, including causes, stages and management in a well organized manner. Perhaps the section on care of the surgical patient is a bit too brief, as it deals only with the physical preparation of the patient and ignores the emotional aspects. Introductory material on tumors includes not only the principles of surgical management, but also summarizes principles of cytotoxic therapy and radiotherapy.

The focus of the remainder of the text is the surgical management of common problems and related disorders. The topics vary in orientation from complete systems (e.g. the central nervous system), to related organs (e.g. the stomach and duodenum), or to specific pathology (e.g. peripheral vascular disease).

On the whole, the text touches only briefly on the implications for nursing care, either in terms of the diagnostic tests described or specific pre and/or postoperative care of the patient. It is true that general information at the beginning of the text is included, and in most cases, common complications are sufficiently outlined to enable the astute nurse to identify appropriate observations and nursing intervention. Perhaps a workbook of nursing application used in conjunction with this text would make it more valuable for the student nurse.

Several topics outlined in the book do not seem to be consistent with current medical and nursing practice and undermine the value of the book as an appropriate reference for the student of nursing in Canada or the United States. Two of the more obvious problems follow:

- In the chapter on care of the surgical patient, the authors recommend that an intravenous infusion needle containing thrombosed blood can be cleared by flushing out the needle with normal saline. Current literature indicates this to be a dangerous practice as it may in fact liberate an embolus which could cause further complications.

- A second area which seems inconsistent with current literature and practice is the statement that the unconscious patient with a head injury should be transported and nursed with his body tilted head downward so that the tongue falls forward and secretions drain from the mouth instead of being inhaled. Such patients are normally nursed in the semi-prone position, lying flat on the bed to reduce the tendency toward increased cerebral edema and intracranial pressure.

In summary, this text provides a useful reference for the review of common surgical problems and procedures and could be a useful adjunct to nursing unit or ward libraries. However, it leaves too many problems for the nursing student who would have to rely on alternative references and sources to correct and supplement the information provided.

Nursing care of the patient with medical-surgical disorders. 2d ed. by Harriet Moidel, Elizabeth Giblin and Bernice Wagner. New York, McGraw-Hill, 1976.
Approximate price \$19.75
Reviewed by Patricia McMullan, Teacher, St. Boniface General Hospital School of Nursing, Winnipeg, Manitoba.

Nurses who are familiar with the first edition of *Nursing Care of the Patient with Medical-Surgical Disorders* will find a significant expansion in the area of nursing diagnosis and management.

The steps in the nursing process are clearly described and examples are given. Of particular interest is a table of data which may be collected in each assessment area. Other new sections which have been added include "Disturbances in Fluid and Electrolyte Balance," "The Patient and Metastatic Cancer" and "Communicable Disease Control in the Hospital."

The text is written by a variety of authors, each an apparent expert in his field.

Part I presents a philosophy of nursing relationships between nurse and patient and concepts of health and reaction to illness.

Part II presents basic concepts of illness, the disease process, the diagnostic process and therapies for disease.

Part III presents a description of significant manifestations that occur in a variety of illness situations and explains them in terms of physiologic and psychologic mechanisms.

Part IV presents an overview of general nursing care of patients who are confined to bed, who have metastatic cancer and/or who are treated surgically as well as discussing methods for infection control.

• Part V presents specific information related to the disease itself and the problems of the patient on which nursing care focuses.

In general the text presents well-organized information; extensive bibliographies and references are included with each chapter.

My personal feeling is that this is a well written text for students in learning nursing care of adults.

It is enhanced by the repetition throughout of rationale for nursing diagnosis and management and the liberal use of tables, charts and diagrams. An important feature is the presentation of concepts rather than endless facts. The only real drawback to this book is the lack of color in diagrams or printing which tends to make reading monotonous.

The strengths of this book lie not so much in the newness of the concepts (e.g. trust, independence, attachment, deprivation) or theories (e.g. pain, developmental, communication) but in the creative

way in which they are blended into nursing strategies. As stated in the purpose, these were personal experiences illustrating effective conceptual strategies. As most of the authors indicate, they were initiated with the hope but not the prediction of, success. A nurse wishing to apply them would have to assess the suitability of a particular concept to meet the needs of the child and family with whom she is dealing and the setting in which she is operating.

I was favorably impressed with the overall content of this well written collection. It would be a valuable resource for professional nurses in any pediatric health care setting. Some of them — particularly those articles relating to stress and hospitalization — would be excellent resources for nursing students.

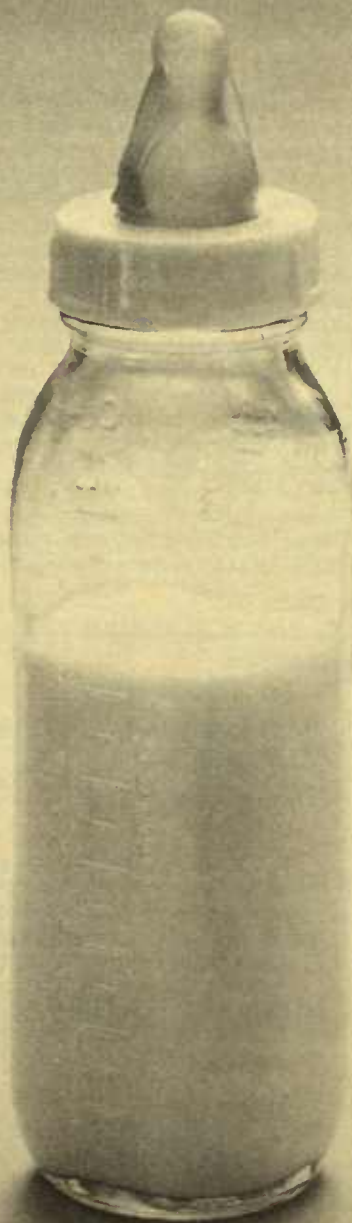
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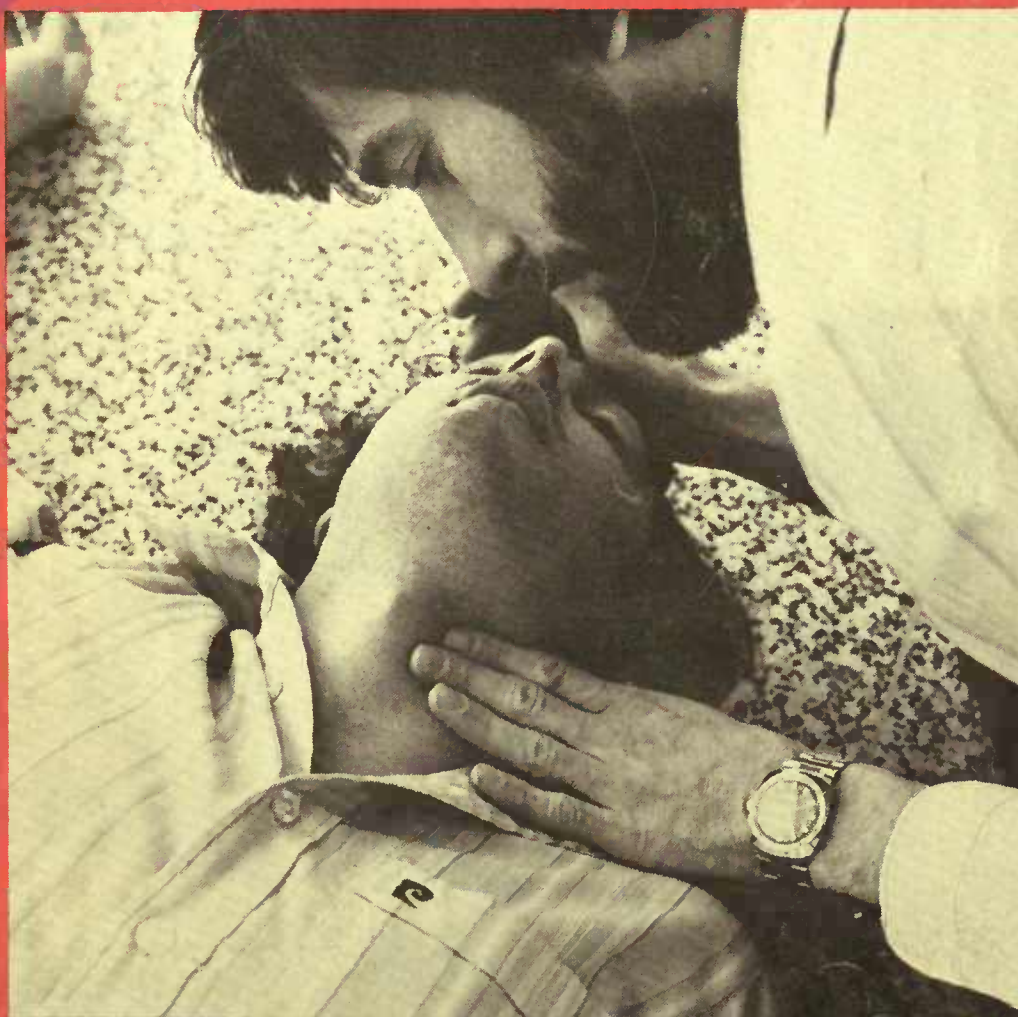
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How long has it been since you updated your CPR skills? Too long? The Canadian Heart Foundation has recently adopted new standards for basic life support CPR for use in Canada. **February is Heart month.** We thought this would be a good time to look at what these new standards have to say about CPR. The photostory begins on page 38 of this issue. On the cover, Ontario Heart Foundation CPR instructor-trainer, Terry Turner, checks the carotid pulse of "victim" Steve Wannamaker. All photos courtesy Studio Impact, Ottawa.

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses Association.

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Guest editorial

Mother's Milk: Is it Safe?

Z.I. Sabry, Professor of Applied Human Nutrition, University of Guelph, Guelph, Ontario.

One morning this Winter, Canadians woke up to the news that some mother's milk may not be safe to give to infants. Announcement of this startling finding came from Ruth Fremes, a specialist in foods and nutrition, and Jack McGaw, long-time producer of the CTV series 'Inquiry'. The Fremes-McGaw team had a mother's milk analyzed and found that it contained more than double the acceptable level of DDT and about six times the acceptable level of PCBs. These chemicals are deadly and the acceptable levels of their residues in foods have been carefully set by the World Health Organization as well as by our Health Protection Branch (of Health and Welfare Canada).

The Fremes-McGaw 'Inquiry', which was entitled "The Failing Strategy," found that the values they obtained on the one mother were representative of values obtained, but not released, by the Health Protection Branch on a large sample of Canadian mothers. The program pursued the subject of the widespread and almost indiscriminate use of pesticides in growing crops and how they get in the soil, into plants, in animal feed, in animal products and in our water supply. Prominent scientists in both the USA and Canada were interviewed. Their suggestions included the imposition of a moratorium on the introduction of new chemicals in our agricultural practices (Dr. Donald Chant, professor at the University of Toronto) and the advice to mothers to send samples of their milk to the provincial health laboratories for pesticide analysis to determine their safety (Dr. A.B. Morrison, assistant deputy minister, Health Protection Branch).

The program was credible in the information it obtained, balanced in the views it presented and unsettling, to say the least, to health professionals. It magnified the conflict that exists between the departments of agriculture and health in our government and between professionals in these two areas. The agriculture strategy is to use an ever increasing amount and variety of chemicals to control pests and weeds. The health profession, on the other hand, is struggling to limit the levels of these chemicals in the food and water supply to protect Canadians from their toxic effects.

Now the big question facing nutritionists, nurses and other health professionals is: "Should mothers breast-feed their babies? If not, what are the alternatives?"

Dr. Morrison has suggested that mothers have a sample of their milk analyzed. Provincial public health laboratories should be equipped to tell mothers whether or not their milk is safe for their infants. Women could help cut down on the risk of having their milk contaminated by cutting down on fat in their diet, both before and during pregnancy and while nursing their babies. Pesticide residues are mainly in the fat portion of the food. So, it would be advisable to trim meat and skin chicken before cooking them. Fish from freshwater lakes (where pollution is high) should be excluded from the diet and only ocean fish should be eaten.

In the event that a mother discovers after several weeks of nursing that her milk is contaminated, she should be able to switch to a suitable milk formula. Apparently, cow's milk is not as contaminated as human milk. Cows eat mainly grass and grains which are low in fat and in DDT and PCBs. They also have four stomachs and a complex digestive system that seems to be capable of destroying these chemicals. Humans, on the other hand, eat a diet that is high in fat (40% of our calories, according to Nutrition Canada). Also, humans probably pass these pesticides on to the mammary glands and to milk more efficiently than do cows.

Nutritionally speaking, human milk is superior to any other. It has the nutrients needed by infants in the right combinations and the exact amounts. Breast-fed babies are not likely to be overfed. Mother's milk, particularly in the first two or three weeks, is loaded with antibodies which protect the baby from infections. So, mothers should breast-feed for at least these first few weeks. If their milk is found to be contaminated (a possibility if they eat high fat diets and live near areas where chemicals are heavily used in industry or in agriculture) they should then shift to baby formulas.

Most baby formulas are based on cow's milk after modification to make them resemble human milk in composition. Usually the minerals are leached, the protein is partially digested and the fat made to be more polyunsaturated. The label should indicate these modifications. The list of ingredients should include polyunsaturated fat such as soy and corn oils without, or at least ahead of (meaning they are in larger amounts than) coconut or palm oil (both are saturated fats).

For babies who show allergy to cow's milk, there are formulas based on soy. The attending pediatrician who would recognize such allergy will be able to recommend a suitable formula.

As much as there should be no reason for panic, there IS cause for alarm. Unless our agricultural practices change drastically, the situation will deteriorate and health hazards will multiply. Indeed, it is time that our elected representatives resolve the nagging conflict that exists between the desire of the department of agriculture to enhance crop yields and the profits of agribusiness and the attempts of the department of health, to protect the health of Canadians.

Guest editorialist Z.I. Sabry is probably best known to readers of *The Canadian Nurse* as the former national coordinator of the *Nutrition Canada National Survey*, a four-year, coast-to-coast study of the eating habits of Canadians, published in November, 1973.

Dr. Sabry is now a member of the Department of Family Studies, College of Family and Consumer Studies at the University of Guelph, was formerly a professor of nutrition at the University of Toronto, and has served as consultant to various international agencies, including FAO, WHO and UNICEF, as well as for the U.S. Public Health Service.

Born in Egypt, Dr. Sabry is a graduate of Cairo University, (B.Sc.), University of Massachusetts, (M.Sc.) and Pennsylvania State University, (Ph.D.).

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Input

Four-score scores!

My husband joins me in expressing our appreciation for the interesting "serial" by Maude Wilkinson in the October and November issues of the CNJ. We are eagerly awaiting December's finale.

My copy of the magazine is sent to a friend in Jamaica, W.I. where we served as CUSO volunteers 1967-69. We know Miss Wilkinson's collections will also be enjoyed there. Miss Wilkinson's literary style reflects the customs and history of the period so nicely. Her inclusion of my friend lends a very personal touch and does not detract from her nursing experiences.

In any event, please express to Miss Wilkinson our best wishes and thanks for sharing her experiences in such an interesting manner.

Rosemary A. Schellenberg, R.N.
Portage La Prairie, Man.

Special Interest group

I thought your readers might be interested to learn that in Manitoba we have set up a Philippine Nurses Association that works with the Manitoba Association of Registered Nurses and is now going into its second year of operation. The purposes of our association are:

- to promote the standard of the nursing profession
- to create and foster a spirit of unity, fellowship and cooperation among nurses
- to promote the educational and professional advancement of members

- to enhance interest in civic and professional activities
- to stimulate a sincere interest for the welfare of Filipino nurses coming to the Province of Manitoba
- to disseminate information about nurses and nursing
- to work harmoniously with nursing associations and/or other Filipino organizations.

Last year, we set up a workshop on nursing registration/education and also organized a review class for out-of-country graduate nurses, as well as cultural and social presentations, and assistance in the Narciso-Perez case.

If other Philippine Nurses Associations exist in Canada we would be very happy to hear from them. If there are none, we encourage you to form one. Let's share our experiences and ideas. Please forward enquiries to Philippine Nurses Association, c/o Edilberta Cantada, 7-582 Osborne St., Winnipeg, Manitoba (tel. 462-4622).

— Solomon M. Guerrero, R.N.
B.S.N., president, Philippine Nurses Association.

Information please

As an employee of a small nursing home out in the country, I find your articles most interesting and informative. We have limited access to resource materials except on a "borrowed" basis.

I would appreciate some information on Korsakoff's syndrome. A number of our residents suffer from this problem, and we have been able to obtain very little reading material on the subject.

Our experience has shown that as with an acute psychosis, the patient does not respond to the usual nursing home techniques of Reality Orientation and T.L.C. Behavior modification, in conjunction with sedation, has been helpful in some instances.

I hope your readers can be of some help.

— P. Bridgewater, R.N., Box 81, St. Adolphe, Manitoba, R0A 1S0.

Science or art?

I would like to comment on a letter from one of your readers (see Name Withheld, November, 1977) in which the author writes: "I do not believe that imposing a pseudoscientific superstructure on what is essentially an applied art will give nursing validity."

By this I gather (1) nursing is not scientific but a refined housewife position (2) nursing is an applied art ... such as macramé.

A nurse is a human being who must work ungodly hours, negating, in many cases, normal home life; a nurse is a trained professional, that believe it or not, cannot be replaced

by a truck driver at a moment's notice; and, as I've found my wife to be, a very intelligent, well-trained and currently informed, in all medical aspects professional.

If you do not think your job makes it necessary for you to upgrade and expand your knowledge of the medical profession, may I suggest you become a janitor — a very necessary applied art. If nurses want to gain their rightful professional position they must start acting like professionals instead of characters in a "Harlequin Romance" novel.

— S.E. Olson, Edmonton, Alta.

Another country heard from

The article by Mohamed H.

Rajabally on nursing education came just in time for me. Being in nursing education for 25 years, I have gone through all the fads. Having very little original professional literature of our own in Israel, we are hanging on to the huge amounts of literature published in North America. We try hard not to lose our direction, and not to follow blindly in the footsteps of any other country. But it is difficult to withstand the trends and to raise a courageous word that a lot of what is said or written is "Much Ado About Nothing" or at least complicating simple things.

What we are trying to do is to make our students think and be able to articulate their thoughts. As long as they are not able to transfer their knowledge to all the other upcropping health professions, they will always be pushed aside and given tasks which are purely routine.

So we are not only looking for "where to hang our hat" but how to use the head below the hat. Trying to change the image of "two pairs of feet and two pairs of hands" is difficult especially as nursing was, is and always will be a DOING profession.

Still, I do think that Rajabally has gone to the other extreme. If he has read the book by M. Levine *Introduction to Clinical Nursing*, he will see that the stated principles are used methodically so as to integrate the sciences for nursing purposes, which is a very realistic approach.

In my opinion, one of the mistakes made in curricula is that the

programs are based on one idea or model only. This, again, causes an artificial system of thought which may cause rigidity besides being perfectly impractical in reality.

The problem is how to steer the vessel through the many modern currents blowing from various ivory towers, and get the thinking, humane, adaptable and efficient nurse we would like to see.

— Miriam Schmidt, Rothschild 162, Petach-Tokva, Israel.

Did you know ...

An Ottawa researcher who has spent the past two years examining child abuse records in Ontario says his findings suggest that:

- girls are more often targets for abuse than boys
- more mothers than fathers abuse their children
- child abuse occurs more frequently in large families (three to seven children)
- the age group most frequently the target of abuse are children from three months to three years
- while fathers tend to abuse their sons more frequently than their daughters, mothers rarely abuse their sons.

Researcher Phillip Graves who came up with these findings, in addition to studying provincial records, interviewed six physicians and 24 social workers during his study.

NEXT MONTH ... WATCH FOR an exciting new feature in your professional journal — a monthly column devoted to the legal aspects of nursing in Canada today. Corinne Sklar, a graduate of University of Toronto's school of nursing, now completing her studies in the faculty of law at the same university, answers your questions about the legal significance of charting and passes along some Do's and Don'ts that will act as a useful reminder for all nurses. Watch for *You and the Law* in the March issue.

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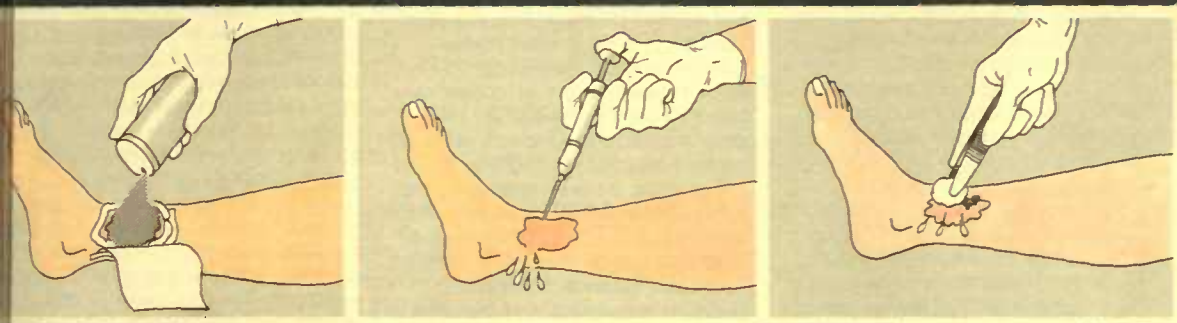
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3. 30 days. Ten days after successful grafting.¹

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3. 21 days. Thirteen days after successful grafting.²

1. An 83 year old male with a decubitus ulcer showing a heavy growth of *Proteus mirabilis* resistant to penicillin G and V, erythromycin and doxycycline.
2. 29 days. The wound culture was negative.
3. 64 days. A minor wound remained.¹

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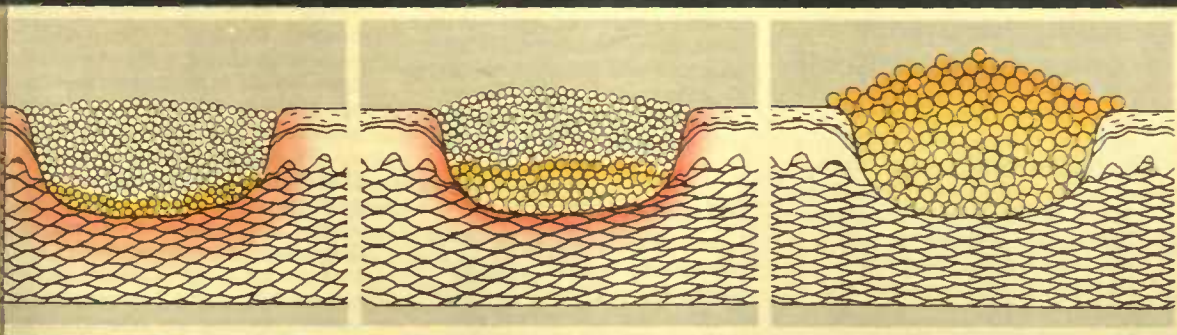
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1. Data on file at Pharmacia (Canada) Ltd.
2. S. Jacobsson et al., Scand J Plast Reconstr Surg 10:65-72, 1976
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News

World conference on primary care

Three nurses will be named to represent the International Council of Nurses at the WHO/Unicef conference on primary health care to be held in Alma Ata, USSR, in September 1978.

The objectives of the Alma Ata conference are to exchange experiences and information on the development of primary health care within the framework of comprehensive national health systems and services and overall national development; and the promotion of primary health care.

The conference is intended to stimulate a discussion among national planning and health authorities on effective ways of promoting health as an important factor in the achievement of development goals and the improvement of the well-being of all people.

Survey shows need for contraceptive education

A recent survey of 209 nurses and student nurses in southwestern Ontario indicated strong support for the provision of contraceptive services to the adolescent population. In spite of the support shown, however, half of the respondents said that they did not feel adequately prepared to work in the area of contraception and many desired more education in this area.

The nurses surveyed expressed considerable interest in the area of contraceptive education, with 95% expressing willingness to attend workshops on the subject and 96% agreeing they would be willing to provide contraceptive education to high school students.

Most of the nurses felt that the solution to reducing unwanted pregnancies lies in emphasis on contraception rather than on abstinence. They were unaware however that these views were shared by others in society. For example, half of the nurses surveyed believed that parents do not accept contraceptive

education in the high schools, whereas surveys indicate that most parents do support such programs. In addition, most of the respondents were unaware that the Canadian Nurses Association has adopted a position favoring contraceptive education.

Most respondents seemed to have a good understanding of why many adolescents do not use contraceptive methods. There was a lack of agreement however on the extent of premarital sexual activity among high school students, suggesting a need for education in this area.

The study, conducted by Edward Herold, Ph.D. and Roger Thomas Ph.D. of the University of Guelph indicated a need for more courses and workshops in family planning, perhaps with additional training in family planning in some nursing schools. It also suggested a need for the evaluation of contraceptive educational and counseling services provided by nurses and other professional groups.

Although surveys have been conducted in the United States regarding attitudes of nurses towards family planning services, there has been little similar research in Canada.

Quality assurance comes to Nova Scotia

Nurses from 18 Nova Scotia hospitals have been involved in a quality assurance program through participation in a series of workshops held in three regions of the province. The themes selected for the workshop were: patient care planning, quality assurance and nursing audit.

Three branches of the Registered Nurses Association of Nova Scotia — Annapolis Valley, Shelburne and Cape Breton -Victoria — organized and coordinated the workshops as part of the RNANS continuing education program. Resource person for the project was Jean MacLean, RNANS nursing service consultant.

Critical Care Symposium held in Toronto

The Toronto Chapter of the American Association of Critical Care Nurses (AACN) and the Health Sciences Division of Humber College hosted the first annual critical care symposium Toronto, last November. Three hundred and fifty delegates, most of whom work in critical care areas, were in attendance. Plenary sessions discussed aspects of burns, multiple trauma, drug effects in critical care disease and a holistic approach to patient care. Workshop sessions, all presented by nurses, dealt with acute respiratory therapy, acid base balance, basics of pressure monitoring and included a luncheon tour of the Cardiovascular Dog Laboratory at the Toronto Western Hospital.

Lynne Gordon, chairperson of the Ontario Status of Women Council, spoke to delegates at a dinner session about the "Role of Women in Today's Society." She urged nurses to become informed and to exercise personal choice in planning their lives and careers.

The Toronto Chapter of AACN was formed two years ago to develop and sponsor educational programs for the continuing education of critical care nurses. It also seeks to promote education and standards of practice for critical care nurses with an emphasis on Canadian methods and achievements.

Did you know ...

A pilot program aimed at immunizing women against pregnancy is planned to begin in Australia some time next year. Professor Warren Jones, chairman of the World Health Organization's steering committee on immunology methods of fertility control, stated that the WHO believes that the contraceptive vaccine would prove to be a safe and cheap method of long-term contraception. The vaccine will be used to prevent pregnancy rather than to induce abortion.

Respiratory Care Society meets

The Toronto Region of the Ontario Respiratory Care Society presented the third fall seminar on Chronic Obstructive Lung Disease at the Royal York Hotel, Toronto.

Dr. Stanley W. Epstein, assistant professor, Dept. of Medicine, University of Toronto discussed **Sarcoidosis**, with particular reference to the pulmonary manifestations of this disease. Dr. Ronald R. Crego, assistant professor, University of Toronto Dept. of Anaesthesia presented a simple, clear, concise review of acid-base balance and the mechanisms involved in acidosis and alkalosis, both respiratory and metabolic. The final paper of the morning was presented by Dr. Roman Bladdek, assistant professor, Dept. of Medicine, University of Toronto, titled "Current Management of Tuberculosis." The paper drew the participants' attention to changes in chemotherapy and treatment of tuberculosis patients and pointed out the degree to which practices dealing with infection control and health teaching have not been modified in response to current knowledge.

Karen Goldberg, O.T., executive director of Community Occupational Therapy Associates discussed sexuality and the C.O.P.D. patient. Knowledge and attitudes of health professionals in the area of human sexuality was stressed in relation to effectiveness of patient counseling.

Peggy Matheson, R.N., Nurse Co-ordinator of the Respiratory Ambulatory Care Program, St. Joseph's Hospital, Toronto stressed the patient education necessary to maintain the C.O.P.D. patient in the community, and the necessity of involving families and others in this process.

Membership in the Ontario Respiratory Care Society, formerly known as the Nurses' Section, Ontario Lung Association, is open to all persons concerned with prevention and health care related to respiratory conditions. More information may be obtained from: Ontario Lung Association, 157 Willowdale Ave., Willowdale, Ontario, M2N 4Y7.

ACCH endorses policies for pediatric health care

The Association for the Care of Children in Hospitals is an international organization set up in 1965 to foster and encourage psychological and social aspects of care of hospitalized children and their families. Membership is open to all professions working within pediatric settings and now includes more than 200 Canadians. Affiliate groups have been organized in British Columbia, Manitoba and the Atlantic provinces.

Recently, the ACCH issued a statement endorsing the following guidelines which may be of special interest to nurses working in pediatric health care settings:

- All pediatric health care settings should:**
- Have a stated *philosophy of care* which is specific, easily understood by, and made available to patients and families, and which applies in a coordinated manner to all disciplines and departments.
 - Assist or provide *programs of prevention and restorative care* which respond to emotional, social and environmental causal factors of accidents and illness.
 - Create and maintain a *social and physical environment* which is as welcoming, unthreatening and supportive as possible, and which fosters open communication, encourages human relationships, and invites involvement of children, their families and the community in decisions affecting their care.
 - Avoid *hospitalizing children* whenever possible through the development of alternatives.
 - Develop and utilize *ambulatory, day and home care programs* which are financially and geographically accessible.
 - Minimize the *duration of unavoidable hospital stays*, while recognizing discharge planning needs.
 - Provide for and encourage the presence and participation in the hospital of *persons most significant to the child*, to approximate supportive home patterns of interactions and routines.
 - Provide consistent, *emotionally supportive nurturing care* for young children during the absence of their parents.
 - Respect the *unique care-taking role of parents* as well as their individual responses, and provide ongoing understandable information and support which will enable them to utilize their strengths in supporting their child.
 - Provide a *milieu* which is responsive to the uniqueness of each child and adolescent, his ethnic and cultural backgrounds and developmental needs.
 - Provide readily accessible, well designed *space, equipment and programs* for a wide range of play, educational and social activities which are essential to all children and adolescents, particularly those who have been deprived of normal opportunities for development.
 - Provide *child care professionals* who are skilled at assessing emotional, developmental and academic needs, communicating with and fostering the involvement of patients and their families in activities appropriate to their needs.
 - Ensure that *children* and their parents are informed, understand and are supported prior to, during, and following experiences which are potentially distressing.
 - Carefully select *all staff and volunteers* according to their commitment to the foregoing policies. Those in direct contact, however limited, with children, youth, and families should be sensitive, perceptive and compassionate. Professionals involved in more extended, intimate and responsible positions of child care should have special training in child development, family dynamics and the unique psychological needs of children when ill and under stress.
 - Facilitate *orientation*, continued learning, and consultation in relation to all of the above, and provide support which recognizes the emotional demands on staff.
 - Encourage and foster the inclusion of the above *educational focus* in the basic curriculum and field experiences of the various professional and technical personnel preparing for careers in pediatric settings.
 - Support the involvement of *resources for early detection*, and of attitudes and facilities for ongoing care of children with health and/or developmental problems.
 - Provide for ongoing *evaluation of policies and programs* by the recipients of care and staff at all levels.
 - Support and disseminate *research* which clarifies and pertains to the above.
 - Promote *education within the community* about the health and developmental needs of children.

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To Be or Not to Be

Still undecided about whether or not you'll take in the 1978 CNA convention in Toronto this June? If so, don't forget that Toronto is only a short bus, car or train ride from two of Canada's most famous exciting summer theatres.

The Shaw Festival summer season at nearby Niagara-on-the Lake, runs from May 11th through October 8th and this year will feature two plays by Bernard Shaw — *Major Barbara* and *Heartbreak House* — as well as Henrik Ibsen's *John Gabriel Borkman*. Housed in a new 830-seat proscenium-stage playhouse and the historic 361-seat Court House Theatre, this professional theatre company is the only one in the world devoted to presenting the plays of Bernard Shaw and his contemporaries.

The Stratford Festival, now going into its 26th year of operation, offers a mix and match program that features seven productions on its Festival Stage, six on the Avon Stage and another five on the Third Stage. The 1978 selections from Shakespeare will include *The Merry Wives of Windsor*, *As You Like It*, *Titus Andronicus*, *Julius Caesar*, *The Winter's Tale*, and *Macbeth*. Other productions include Anton Chekhov's *Uncle Vanya* and John Whiting's *The Devils*, as well as a musical adaptation of Voltaire's *Candide*.

So, whether it's Shaw or Shakespeare — Niagara or Stratford — that catches your fancy why not plan now to extend your convention visit by a day or two and take in at least one theatre production. You'll be glad you did! For further information about tickets and accommodation write to either:

- Shaw Festival Theatre Foundation,
Box 774, Niagara-on-the-Lake,
Ontario, L0S 1J0.

or

- Stratford Festival
Box 520,
Stratford, Ontario, N5A 6V2.

COMING NEXT MONTH ...YOUR OFFICIAL CNA CONVENTION REGISTRATION AND ACCOMMODATION FORM

The March issue of *The Canadian Nurse* will include an official registration form with information on where to stay in Toronto during your convention visit. Watch for the bright yellow and green pre-registration card in the next issue.

Canadian Nurses Foundation

In accordance with By-law Section 36, notice is given of an annual and special general meeting to be held on Sunday, 25 June 1978 commencing at 2:30 p.m. at the Royal York Hotel in Toronto. The purpose of the meeting is to receive and consider the income and expenditure account, balance sheet, and annual reports.

The election of the CNF Board of Directors for the 1978-80 term of office will be conducted during the meeting.

Members will be asked to consider the deletion of By-law Section 10 item (ii) and a related change in By-law Section 12.

All members of the Canadian Nurses Foundation are eligible to attend and participate in the annual and special general meeting.

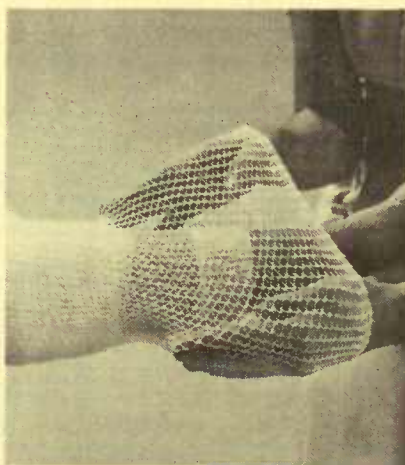
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Out of Bed

You have probably lost count of the number of patients you have helped out of bed within 24 hours of their abdominal surgery. But are you doing it in a way that causes minimum discomfort to your patients? Let's take another look:

First lower the bed or bring a safe foot-stool to the bedside. Have the patient's slippers, bathrobe and a comfortable chair handy.

Ask the patient to flex his knees, then assist him to turn towards the operative side. Raise the head of the bed as high as possible.

Help the patient to a sitting position with his legs over the edge of the bed. Because he is turning towards the operative side, he will be using those muscles on the side of the abdomen and back that were not operated on.

While he is sitting on the bedside, encourage him to take several deep breaths. Help him with his slippers and bathrobe. Then have him stand at the bedside. If he feels faint, have him do several stepping motions.

If his color is good, encourage him to walk 15 to 20 feet before sitting in the chair. Use the time for tidying his unit to keep an eye on your patient.

Using the proper procedure makes a big difference to your patient's comfort and recovery.

*Marjorie Hewitt, Nursing Consultant,
Saskatchewan Registered Nurses'
Association, Regina, Sask.*

Pre-op Teaching

Teaching deep breathing to a preoperative patient is sometimes more difficult than it would seem. We use the following method to give the preoperative patient an idea of the amount of energy needed to take a really deep breath.

Wrap a towel around a patient's chest. Have him hold onto the two ends of the towel and pull the towel really tight on expiration. This not only helps him to understand what deep breathing means, but it gets him actively involved in his care.

*Evelyn Schaller, Head Nurse, 6 North,
Victoria General Hospital, Halifax, N.S.*

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Names and Faces



Beverlee Cox, currently on faculty at the University of British Columbia School of Nursing has been appointed to the deanship of the Faculty of Nursing at the University of Western Ontario, London.

The appointment is for seven years and is effective early this summer.

Professor Cox holds a B.Sc.N. and a Master of Science degree from the University of Hawaii, and a Ph.D. from Simon Fraser University.

Her professional experience began in 1963 as a nurse at Queen's Hospital in Honolulu. Following graduation from the University of Hawaii she was a junior research associate there, then in 1970 was appointed nurse clinician in the Health Sciences Centre Psychiatric Unit of UBC, and clinical assistant professor of the UBC school of nursing.

In 1976 she was appointed associate professor at UBC, the post she now holds. Her professional activities include a term on the federal task force on Planning of Mental Health Programs in Canada and she has been active in many professional nursing organizations.

Members of the Canadian Nurses Association task force on the "Protection of Life" project are:
Lesley Degner, associate professor and research associate, school of nursing, University of Manitoba, Winnipeg;
Norma Wylie, associate professor, school of nursing, Dalhousie University, Halifax;
Lorina Friesen, Cancer Control Centre, Vancouver;

Betty Youson, nurse-coordinator, dept. of genetics, Hospital for Sick Children, Toronto;
Karen Cannon, intensive care unit, Regina General Hospital, Regina;
Sheila Hunter, critical care coordinator, Foothills Hospital, Calgary;
Andrée Galarneau, transplantation unit, Hôpital Maisonneuve-Rosemont, Montreal;
Suzanne Brazeau, director of family planning, social service programs branch, Health and Welfare Canada, Ottawa;
Patricia Gorman, assistant director of the VON, Ottawa-Carleton Branch, Ottawa.

This nursing task force has been set up in a response to an invitation from the Law Reform Commission to help in their "Protection of Life Project," a project which will deal with euthanasia, a definition of death, human experimentation, behavior modification and control.



Elizabeth Ann Taylor has been appointed director of community health nursing for the City of Vancouver Health Department. A graduate of the Victoria Hospital School of Nursing in London, Ontario, Taylor obtained a B.Sc.N. in Public Health in 1963 at the University of Western Ontario and a M.S.N. (Administration) at the University of British Columbia in 1970. She has been employed in public health nursing in Ontario and was the executive assistant to the director of nursing at the Vancouver General Hospital. Most recently, she was assistant executive director of the RNABC.

Thérèse Poupart a graduate of the University of Montreal's Faculty of Nursing is the recipient of the Warner-Lambert Canada Limited Nursing Fellowship Award made annually by the company's Warner-Chilcott Laboratories Division.



Poupart (left) received the \$750. award from Yves C. Bordeleau, Field Sales Manager, Quebec/Maritimes, Warner-Chilcott (right). In the center is Jeanne Reynolds, dean of the University of Montreal's Faculty of Nursing.

The award is made available each year to a nursing graduate to assist the nurse in furthering her knowledge and experience in the field of nursing.

A London, Ontario nurse, **Leslie Key** of RNAO's Middlesex chapter, has been instrumental in setting up Canada's third Pacemaker Club for pacemaker recipients.

Key, who is now attending University of Western Ontario and working towards her B.Sc.N., has been involved in cardiovascular nursing for 13 years.

The idea of forming the club grew from her interest in the cardiovascular field and her involvement in an interdisciplinary Pacemaker Symposium in February of 1977.

"The purpose of the club is to help pacemaker recipients to get together to discuss their situation and to learn better how to cope with their unique problem," said Key. "I'm really delighted that those who attended have taken the initiative to form the club and to direct its activities."

New Appointments

Neil Campbell was recently appointed director of Labour Relations for the New Brunswick Nurses' Provincial Collective Bargaining Council (PCBC). A graduate of the University of Alberta, Campbell gained his collective bargaining experience with the City of Edmonton as Labour Relations Officer from 1974-77.

Campbell replaces Glenna Rowsell, who left PCBC to become the new director of Labour Relations Services for the Canadian Nurses Association.

Sheila Ryan is the new director of nursing at UBC's Health Sciences Centre psychiatric hospital, Vancouver B.C.

Ryan is a graduate of the Alfred Hospital's School of Nursing in Melbourne, Australia and holds certificates in midwifery and psychiatric nursing. She received her Bachelor of Science degree in Nursing and Master of Health Services Administration degree from the University of Alberta. Most recently, she was associate vice-president, nursing at the University of Alberta Hospital in Edmonton.

Her nursing experience includes psychiatric, pediatric, obstetrical and surgical nursing as head nurse, clinical instructor, supervisor and associate director of nursing.

Amelia Mangay-Maglacas has been named the "Focal Point for Nursing" for the World Health Organization. She will retain her present position as senior scientist for nursing, Health Manpower Development Division, WHO.

In her new capacity, Maglacas will have five major areas of responsibility, among them to represent WHO in all nursing related activities and to keep WHO informed on nursing issues and problems.

This appointment will serve to facilitate relations between the International Council of Nurses and WHO on nursing matters of mutual concern, particularly in utilizing resources in developing nursing's contribution to health throughout the world.

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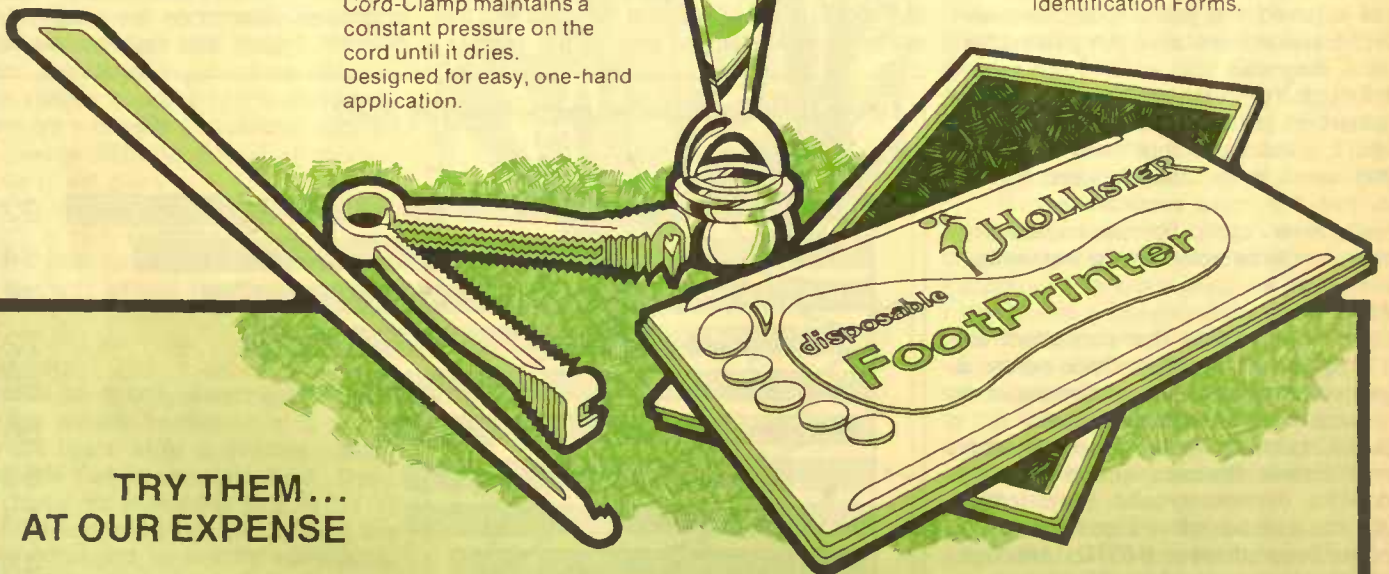
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Systemic lupus: a patient perspective

How much do patients with systemic lupus erythematosus know about their disease, its treatment, and necessary changes in lifestyle? What concerns do they have, and how do they rank these concerns? Author Bonnie Hartley set out to find answers to these questions. The answers are interesting, and more important, let us know about the ways we as nurses can help ...

Bonnie Hartley

Until recently, systemic lupus erythematosus (SLE) has been considered a rare and terminal illness. Now, it is recognized that the disease is neither uncommon nor inevitably fatal.

In 1953, roughly 20 percent of SLE patients survived five years; today, between 80 and 95 percent are alive ten years after the initial diagnosis.¹

Although the exact incidence figures for SLE have not yet been determined in Canada, it is estimated that there are about 500,000 cases in the United States.² This means that it is more common than rheumatic fever, cystic fibrosis, muscular dystrophy, multiple sclerosis, or leukemia.³

What is it?

SLE is a vasculitis that can affect any organ or system of the body. Once named a collagen or connective tissue disease, it is now described as collagen-vascular.

Lupus is closely related to several other systemic chronic illnesses such as scleroderma, dermatomyositis, polyarteritis nodosa, rheumatoid arthritis and mixed connective tissue disease (MCTD). Although each of these diseases have distinct features, they have much in common and thus the principle nursing implications are similar.

The cause of SLE remains a mystery, the subject of continuing research. It is believed that either a slow or latent virus, or a non-specific tissue injury in susceptible individuals begins the immunologic response found in lupus.⁴

Regardless of the exact nature of the initial problem, what happens is that endogenous antigens are released; the body

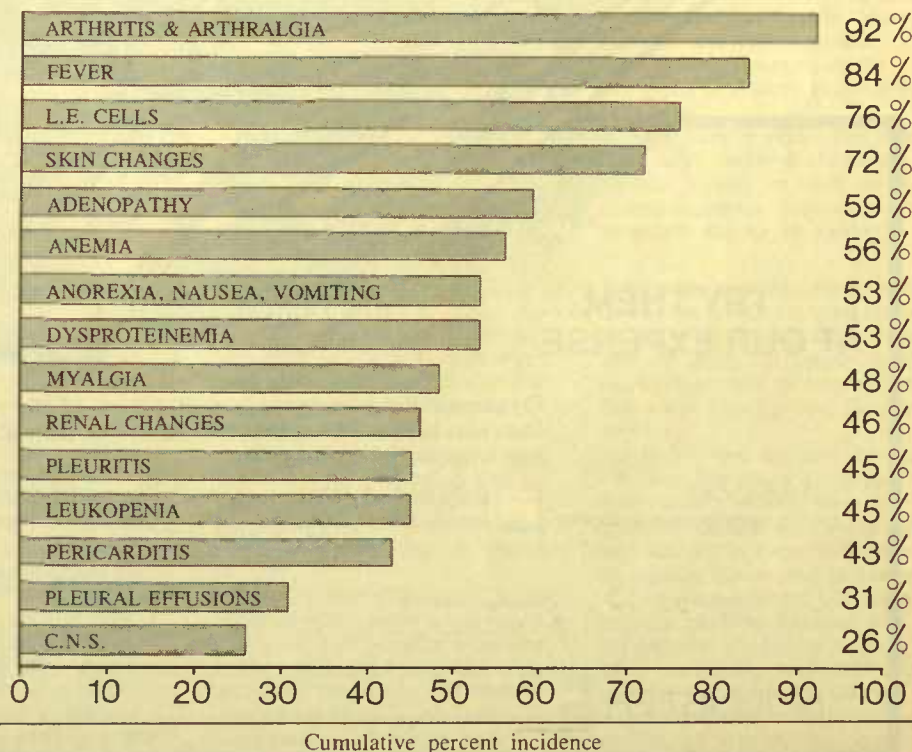
fails to recognize these antigens as its own; and so produces autoantibodies.

Initially, it was thought that these antibodies attacked and damaged the tissues. Now it is believed that these antibodies combine with the nuclear material of the cell, material which is released into the systemic circulation as part of the normal

process of cell turn-over and renewal. The combination of these antibodies (known as antinuclear antibodies) with the nucleus and other cell components, sets up a harmful reaction in the small blood vessels of the body. The amount and type of these antibodies determines the extent to which different organs and systems are affected.

Figure 1: Common clinical manifestations of SLE¹³

(Chart modified from Dubois)



What happens?

Because lupus can affect any organ or system of the body, there are many varied signs and symptoms. Symptoms may be vague — for example anorexia, weight loss, constipation, and fatigue. With the majority of patients "the symptoms are diffuse and systemic in nature, and more prominent than objective findings on physical examination."⁵ Figure 1 portrays the most common clinical manifestations.

Looking briefly at some of the more common signs and symptoms:

Arthritis occurs frequently and tends to be non-deforming. Individual attacks may last from several hours to a few days, then subside, only to recur at varying intervals. Arthritic pain is often greater than the appearance of the involved joint would suggest.

Some form of **rash** is quite common. Not every patient has the characteristic butterfly rash across the nose and cheeks that so many people associate with SLE.

Renal complications comprise one of the more serious aspects of the disease.

There are a number of problems such as pericarditis, pericarditis and pleural effusions that cause **chest pain**.

Pain in the costal-chondral tissues (an **E. chest**)⁶ is fairly common. This pain may occur with a mild flare up of the disease and is often the only clinical manifestation of a flare.⁷

Treatment

There is no specific treatment for SLE. Patients are usually treated on a symptomatic basis. Most authorities stress that adequate rest is very important. The drug of choice for managing SLE is cortisone. Aspirin and motrin (ibuprofen) are commonly employed for arthritic symptoms, and antimalarials such as aralen (chloroquine phosphate) may be used, particularly for skin problems.

Immunosuppressives such as imuran (azathioprine) and cyclophosphamide may also be used in the treatment of SLE.

Prognosis

I have already stated that the prognosis for patients with SLE has definitely improved. The picture presented in dated medical and nursing texts is both frightening and inaccurate; most authors speak of a characteristic pattern of remissions and



exacerbations. But more recent authors present a more optimistic picture. For example Fries and Holman claim that if fluctuations in disease activity are smoothed out, the natural history of SLE in most patients is one of maximum disease activity in the first few years, with a gradual improvement to lesser or absent disease after a period of time.⁸

The patient who has lupus is dealing with a chronic disease with variable symptoms; this fact has important implications for him and for any nurse who contacts him.

Finding out patient's perceptions

An individual with SLE must learn to cope with the limitations imposed by his disease and to avoid any of those factors that could cause an exacerbation. As nurses, we have an important role in helping the patient and his family adapt to a chronic illness, and to make those changes in lifestyle that will help accommodate the disease.⁹ But before any nurse can support the patient with lupus (or his family), she must appreciate the patient's perception of his illness, how he is experiencing the changes brought about by his condition.

A questionnaire

In order to have some idea about how individuals with lupus perceive their disease, I distributed a questionnaire to a convenience sample of 22 lupus patients who were attending clinics at a large teaching hospital. I wanted specific answers to the following questions:

- How much do patients with SLE know about their disease, its treatment and lifestyle modifications?
- What concerns do patients with SLE have, and how do they rank these concerns?

The questionnaire was made up of three parts: demographic data, a test of knowledge, and a section dealing with potential concerns. A list of concerns, 45 in all, had been drawn up a year previously through interviews with patients who had lupus. Using this list as base, an index of concerns was developed. Patients were asked to designate the amount of worry they felt about each item on a scale ranging from 'a great deal of concern' to 'I've never thought about this before.' Patients were also asked to number their three greatest concerns in order of importance to them.

What patients know

The knowledge level of the patients surveyed generally seemed to be quite good — the mean of the test scores was 83.2 percent. There were however, certain vital areas that were not handled well, and these have important implications for our teaching. These essential topics included:

- knowledge about avoiding people with infections;
- the first sign of an infected cut or scratch;
- factors which may lead to an exacerbation; and
- the value of blood tests in the early detection of an exacerbation.

Some of the patients had been hospitalized previously. While in hospital, they had had the benefit of an informal teaching program. Generally, these patients performed better on the test than patients who had not been exposed to this teaching.

But 86 percent of the respondents indicated a need for more printed information about SLE. Many of the patients pleaded for "something to read" about their disease, and asked me where they could find it.

Patient concerns

When patients were asked to indicate the items causing them a great deal of concern, the three items selected most frequently pertained to the chronicity of SLE, having to change or terminate employment, and weight gain. Patients who had been diagnosed for a longer period of time indicated a slight increase in the number of items they labelled as causing them 'a great deal of concern.' Patients with a broader knowledge base noted fewer areas causing them 'a great deal of concern.'

When asked to number problems in terms of the first three items causing the most concern, 'weight gain' headed the list. In second place were two concerns: 'knowing I'll always have lupus,' and 'thinking lupus may run in families.'

● **Nursing implications**

Having SLE can be a confusing and frightening experience, especially at first. The newly diagnosed patient may be faced with a sombre misrepresentation of the facts. Few patients or their families have ever heard of systemic lupus erythematosus. Unfortunately, the few lay persons and many nurses who recognize the name connect it with death.

The media do not help. When television 'medical' shows have portrayed SLE, they have done so in a heavy dramatic fashion — the heroine inevitably 'goes away to die.'

It is anxiety provoking for the patient to find that his disease has no cure, even when it is stressed to him that he should be able to live a normal or near normal life. It is a part of our caring therefore, to understand the confusion and anxiety a newly diagnosed patient must feel, and to clear up the misconceptions that he may have.

In the acute stages of the disease, there is no specific nursing care. SLE can affect any organ or system in the body, so nursing care, like medical treatment, should be assessed, planned, implemented and evaluated on a symptomatic basis.

For example, the lupus patient with acute arthritis should be managed like other arthritic patients. It should be remembered in giving care that subjective symptoms — for example, pain — may be much greater than objective findings would suggest. A number of patients have talked at length about the frustration they feel when members of the health care team do not take this into account.

Physical nursing care is only a part of the care needed by patients with SLE.

Checklist for Education of the Lupus Patient

1. Factors which lead to a flare
 2. Early warning signs of a flare
 3. Drugs
 4. Family planning
 5. Importance of blood tests and checkups
 6. Rest
 7. Facts about ultraviolet radiation
-

Teaching and counseling are an important responsibility, not only for the nurse working in an acute care setting, but for every nurse, whether in the hospital, clinic, community or doctor's office, wherever she meets the patient with SLE.

Counseling is not necessarily an elaborate, formal process — what really counts is taking the time to listen. If the patient feels he can express his concerns, he is better able to deal with them by talking them through when they occur. Many nagging worries can be eliminated and

others kept in healthy perspective through the simple process of communication and feedback.

The questionnaire determined that patients do want more information, but that many already have a fair knowledge of the disease. For this reason, it is important for nurse to assess the patient's knowledge base and build upon it. The following are specific areas that need our special attention when we teach the patient with lupus.

• *Factors leading to a flare*

Although all the factors leading to an exacerbation are not yet known, certain factors have been implicated, and patients need to know about them. Overwork, insufficient rest (physical or emotional), certain drugs (especially the sulfonamides) and (according to some authorities) vaccine may cause an exacerbation. Abruptly stopping medications, especially cortisone may lead to a flare as well.

Patients should know how important it is to avoid infection, to keep their distance from others with colds and infections like chicken pox. They should also be taught to wash cuts and scrapes carefully so that they do not become infected, and to be familiar with the early signs of an infected cut.

• *Drugs*

Patients need to know all about their drugs and possible side effects. Any patient on long-term drug therapy should be encouraged to wear a 'medic alert' emblem or other form of identification for emergency purposes.

• *Family planning*

In the past, patients with SLE have not been encouraged to have children; it was thought that pregnancy could bring on an exacerbation. Now however, because of newer management techniques pregnancy is usually allowed once the disease is in remission. During pregnancy, the patient is closely followed by an obstetrician and the doctor responsible for control of lupus. Generally, forms of birth control other than the 'pill' or an I.U.D. are advocated.

• *Blood tests and checkups*

SLE patients often find the necessity for frequent trips to the doctor and unending blood tests annoying. But some of the newer blood tests, such as the anti-DNA, make it possible to pick up signs of an exacerbation at an early date. The importance of these tests needs to be stressed to a patient, and

positive reinforcement given when patients arrive for blood tests and checkups.

Rest

Most people with SLE require at least eight hours of sleep at night. But the amount of sleep is unimportant; what is important is that the patient avoid becoming overtired. Emotional rest is sometimes difficult to achieve; this is why a good listener can prove invaluable to the patient with lupus.

Warning signs

An exacerbation may be heralded by fever, chills, fatigue, loss of energy, anorexia, the return of an old symptom or the appearance of a new symptom.

Patient Reactions to Lupus

"You have to live with it 24 hours a day and it takes a great deal of courage."

"Don't worry, it's not all that bad... it's not the greatest either."

"Living with Lupus will be your way of life."

"It's a bit tedious in things like it demands a lot of time and care... a lot of caution."

"It makes you feel older, young."

"There's worse things than Lupus."

Photosensitivity

Photosensitivity seems to be something that many people associate with SLE. But not all patients are sun-sensitive. Most studies indicate that between 20 and 35 percent of patients with SLE are affected adversely by the sun.¹⁰ Some authorities state that individuals change in the degree of sensitivity as the disease process changes.¹¹ Many say that a gradual increase in exposure to the sun can usually be tolerated by most SLE patients.

It is thought that the sun's ultraviolet rays damage the cell nucleus and let its components escape. In certain individuals with lupus, exposure to the sun can lead to a full flare up, but in many others, it may only cause a slight fever, malaise, or a rash.

What does the sun-sensitive patient need to know? There are excellent sunscreens available on the market. Pabanol* or pabafilm** is often



recommended, and leaves a film on the skin after swimming. Unfortunately, it can stain clothing, but the stain can be washed out easily. There are a number of commercial preparations containing 'paba'; they serve as effective protection from sunlight.

Many sun-sensitive individuals can go out for 10 to 15 minute periods without using a sunscreen. Dubois warns that "dogmatic advice concerning prohibition of UV exposure should be avoided, as it may do more harm to the mental outlook of patients with chronic illness than any physical damage which might occur."¹²

If a patient is highly sun-sensitive, certain additional facts should be given to him. Most ultraviolet rays are present between nine a.m. and four p.m. (true suntimes). Many outdoor activities can be scheduled outside these peak hours. Bright, cloudy days are as dangerous as sunny days. Cement walks, windows, snow, water, even white buildings reflect the sunlight and can therefore be dangerous. Big hats, long sleeves and slacks can serve as effective sun blocks. Window glass stops most, but not all, ultraviolet rays. Sunlamps must be avoided. Certain drugs, like chlorthalidide may increase photosensitivity.

Resources

Most patients with SLE are anxious to know more about the disease and often ask for printed information, particularly material dealing with necessary modifications of lifestyle. Unfortunately, there is little such material available in Canada. One exception is a free booklet entitled *SLE* which can be obtained from the Canadian Arthritis Society. But this booklet offers little help with changes in lifestyle or understanding the treatment regime.

There is a great deal of printed information available from the United States — some of it is excellent; some, frightening. But finding out where to obtain it can be a big problem for the patient with lupus. Patients should know what printed material is reliable; so much of it is misleading. One of the better, newer booklets is *Living with S.L.E.* by Epstein and Clewley. This costs \$2.00 and can be obtained by writing: Millberry Union Bookstore, 500 Parnassus Ave., San Francisco, Ca., 94143.

What about clubs? A number of patients have expressed their interest in forming a club to facilitate education, the exchange of



ideas, provide mutual support, and reduce the sense of isolation felt by patients with SLE. The only group of this type in Canada of which I am aware is a club in Calgary, Alberta, a group that is working hard to educate their members and others in the community about SLE. Similar clubs in the U.S. are reportedly very supportive of patients with SLE and their families.

Medical advances have added years to the life of the patient with SLE. Our role as nurses gives us the opportunity to help the patient live a normal or near normal life. To do this we must know about the disease. We must understand how each individual patient sees this disease. And then we need to take our teaching and counseling roles seriously, assess our own ability to assume them, and deliberately assign high priority to making them a vital part of our care. ♣

Bonnie Hartley, author of "Systemic lupus, a patient perspective" and "Now, you're on cortisone" is a graduate of Kingston General Hospital and Queen's University, Kingston, Ontario. She obtained a M.Sc.N. degree from the University of Western Ontario. The research mentioned in this article was completed as a course requirement at the University of Western Ontario.

Bonnie is presently employed as a teacher at Ryerson Polytechnical Institute, Toronto. She is also the author of "I've got a wolf by the ears" (CNJ, January 1974).

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- 12 Dubois, op. cit. p. 290
- 13 Dubois, op. cit. p. 258

A note to nurses

Patient education is one of our most important functions as nurses. Patients want to know about their disease and its treatment, and are more likely to comply with a treatment regimen if they are well-informed.

One method of patient instruction lies in the provision of pertinent printed material. This material provides information, and gives guidance for questions. A pamphlet or brochure cannot do all that is necessary in patient education — it offers no opportunities for questions, no consideration of the patient's feelings, and no occasion for the nurse to assess whether or not he understands. When we give out printed information, it is so important that we return to the patient to estimate his comprehension and answer any questions that he may have.

The following is a teaching package for the patient taking cortisone. We all know that the corticosteroids are being used to treat patients with a wide variety of conditions. However, there seems to be a considerable amount of fear and lack of knowledge in patients taking these drugs.

There does not seem to be a great deal of printed material available for the use of patients. This self-instructional package was designed to fill a void as far as corticosteroids are concerned. It does not include all the information available on corticosteroids, but stresses the information needed by patients who are taking these drugs.

Now you're on cortisone

A TEACHING PACKAGE

by Bonnie Hartley

Your doctor will be giving you a prescription for cortisone — a drug you are to take regularly until you don't need it anymore. Cortisone (actually, prednisone is the name of the preparation most commonly ordered) is a very useful and effective drug. Like all drugs, and especially the most potent ones, cortisone has several possible side effects, and may cause serious problems if it is not taken correctly.

Because you are taking cortisone, it is important for you to know as much about the drug as you can. This teaching package tells you:

- why you are taking this drug;
- the proper way to take it;
- precautions and possible side effects.

The following will give you the facts about cortisone and then ask questions about the information given. *Cover the answers (in the right hand column) as you go through the teaching package.* Your answers can be written in the spaces provided and then checked against the answers supplied.

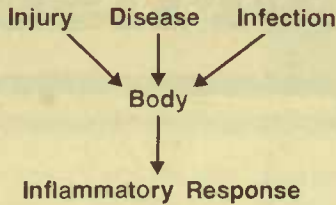
The teaching package is yours to keep. You can return to it at a later date if you find you want to check any details you might have forgotten. It is not necessary to complete all of it at once. If you find yourself getting tired, have a rest and do the remainder at another time. There is a place at the end to jot down any questions you may want to ask your nurse or doctor.

We have mentioned only two of the names which you may hear cortisone called. Your prescription probably says prednisone. Your doctor may refer to it as a corticosteroid. You may also hear it called a steroid. There are other names which you may hear less frequently, but

<p>PREDNISONE = CORTISONE = CORTICOSTEROID = STEROID</p>

1 ACTION OF CORTISONE

When your body has to cope with an injury, infection or disease, it responds by what is called the inflammatory response.



This inflammatory response is something familiar to all of us. It happens when you get dirt in a cut finger or skinned knee and it gets red, warm, sore and swollen. The intensity of the inflammatory response varies with the cause.

What happens when your body has to cope with an injury, infection, or disease?

an inflammatory response

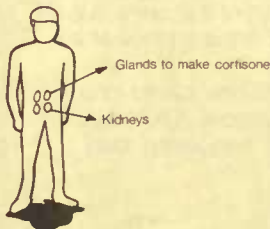
Such an inflammatory response or inflammation may be one reason why you have not been feeling well, or have been experiencing pain. Prednisone is used in your treatment because it alters the normal inflammatory response. It does not remove the cause of the disease or repair the damaged tissue, but it changes the way your body reacts to inflammation, and should make you feel better.

Cortisone is a treatment, not a cure.

What does cortisone do to your body?

cortisone changes the way
your body reacts to inflammation

Did you know that your body produces a substance very similar to cortisone? To avoid confusion, we'll call it cortisone. This cortisone is produced by two small glands located above the kidneys. It has many complex actions in the body; one of these is to lessen the inflammatory response and its effects.



The cortisone produced by your body has many effects; one of which is to

decrease or lessen the
inflammatory response

These glands that produce cortisone are very sensitive. When you are receiving extra cortisone — for example, when you take prednisone, they do not produce as much cortisone as they did before. It is for this reason that once your doctor has started you on cortisone, you must take it regularly until he tells you how and when to decrease the dosage and stop it. By decreasing the dosage slowly, your own glands will gradually return to their normal production levels.

Cortisone must be taken _____ and decreased _____ as your doctor orders, to allow your own glands to _____

regularly
return to normal production

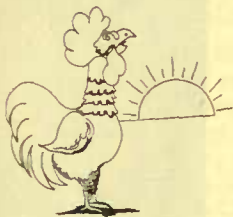
2 HOW TO TAKE CORTISONE

It is very important that you always take your pills. Never stop taking them for any reason without letting your doctor know. Don't skip a dose. If you stop the drug suddenly, you may get very sick. Even when you are feeling better, it is important to take your prednisone until your doctor tells you to stop. It is probably the prednisone that is making you feel so well.

It is important to take prednisone
(check the correct answer.)
☐ only when you wish to
☐ only when you feel sick
☐ regularly, without fail.

regularly, without fail

Doctors have found out that the best time to take cortisone is in the morning. Your body normally provides you with a 'burst' of cortisone in the morning to help you to cope with the stresses of the day. To help you to take the drug regularly, and to mimic your body's production of cortisone, it is a good idea to take it with your breakfast. Your doctor may tell you to take your prednisone every morning, or every second morning. Taking it with food also helps stop your stomach from being irritated.



Cortisone is best taken in the _____ with _____.

morning

breakfast

Sometimes, your doctor may want to spread the effects of the cortisone over the full day. In this case, he will tell you to take your pills twice or even three times a day. Regardless of how often you take the drug, it is important to take it regularly. To prevent irritation of your stomach, it is a good idea to take it with milk or food.

Cortisone should be taken regularly, with _____ or _____ to prevent stomach irritation.

milk

food

3 SIDE EFFECTS

Prednisone has many different effects on your body. It usually makes you feel better. But some of its effects are unpleasant. They may be called side effects. If you know what they are, they will not surprise or alarm you.



Cortisone, like other drugs, has unpleasant _____

side effects

When your dosage of prednisone is high, side effects are more likely to occur. You may wonder "what is a high dose?" This is difficult to define, but as a guideline, a dosage of 25 mg or more per day is considered high. As your dosage is decreased, side effects usually decrease also.

Side effects usually decrease with a _____ in the dose.

decrease

Side effects are unpredictable. They vary with the dose and with each person taking the medication. These are some of the effects you might experience.

Effect	Comment
1. You will feel much better; you may want to eat and eat.	If you give in to your desire to eat more, you may gain weight. Try eating small amounts more frequently.
2. You may retain fluid. This is called edema.	This is very common. You may notice that your ankles are swollen, your rings are tighter or you are gaining weight even though you are not eating more than usual. Cutting down on your salt intake may help.
3. You may feel very happy or very sad at times.	Variations in mood are always natural, but these are often more noticeable while you are on prednisone.
4. At a checkup, your doctor might tell you that your blood pressure has gone up.	If this happens, your doctor will give you advice as to the treatment.

What four side effects may develop?

1. _____
2. _____
3. _____
4. _____

1. weight gain
2. retaining fluid (edema)
3. mood swings
4. increased blood pressure

If weight gain becomes a problem, talk to your doctor or your nurse about it and they can advise you on ways to control excessive weight gain.

If you need high doses of prednisone for a long period of time, there are some different effects that might occur:

Effect	Comment
1. Your face may become round and full.	It helps to know that when the dose is decreased, your face will start to return to its normal shape.
2. Your hair may fall out.	Naturally, this is upsetting. You might try a new hair style, wear a stylish scarf or even buy an attractive wig. When your dose is reduced, your hair will grow again.
3. You may find you have more hair on your face than usual. (A woman may develop hair around the nipple on her breasts).	Any extra facial or nipple hair will disappear when your dose is reduced.
4. You may develop acne or skin blemishes.	These, too, will disappear when the dose is reduced. If you think this is very severe, ask your doctor to refer you to a dermatologist (skin doctor).
5. In women menstrual periods may become irregular or even stop for a few months.	These, too, will return to normal with a decrease in the dosage of the drug.
6. Cuts and bruises may heal more slowly.	It is important to take care of even small injuries. Be sure to keep cuts very clean to avoid infection.

What six side effects may develop if you are on high doses of cortisone for a long time?

- _____
- _____
- _____
- _____
- _____
- _____

- 1. full, round face
- 2. loss of hair on head
- 3. extra facial hair
- 4. acne
- 5. menstrual irregularities
- 6. slow healing of cuts and bruises

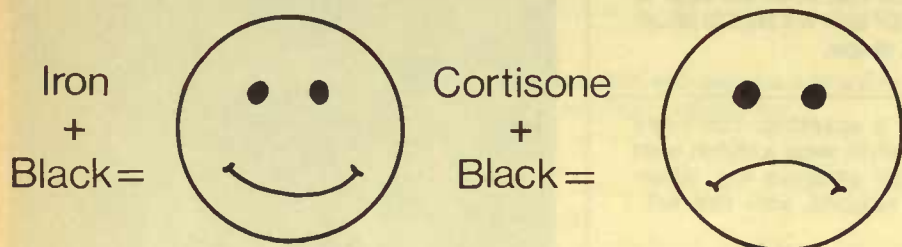
These side effects gradually _____ when the dosage of the drug is reduced.

disappear

There is a lot of information in this section; if you missed one or two things, it would probably help to reread this part.

Very rarely, more serious side effects occur. If they do, call your doctor immediately. The warning signs are stomach pains, vomiting (especially if it looks like coffee grounds) or a black bowel movement.

(If you happen to be taking iron pills at the same time, they can also make your bowel movements black, so don't worry about it, but let your doctor know, and he can find out the cause.)



You should call your doctor if you have _____, _____ or _____.

stomach pains, vomiting
black bowel movements

There are still a few more things you should know about if you are on prednisone. When you take cortisone, your body cannot fight infections in the same way that it normally does. Therefore, you should try to avoid people with infections and colds as much as possible. And if you have to deal with unusual stress, such as severe injury, illness, infection, or emotional upset, your body may require extra cortisone, so you should talk to your doctor if these upsets occur.

When you take cortisone, try to avoid people with _____ and _____. If you face extra stress, like an injury, illness or emotional upset you should _____.

colds
infections
contact your doctor

Do you recall that extra cortisone suppresses the normal production of cortisone by your body? This is why you need to take your cortisone regularly. Your family and friends should also know that you take cortisone, and something about your problem. Then, if an emergency does occur, they are able to let the doctor know.

It is also a good idea to wear a 'medic alert' emblem. In the case of an emergency, this alerts those caring for you to the fact that you are taking prednisone. It also provides them with an emergency phone number, so they can call for more information about your medical problem.

It is important for you to wear a _____ so that your need for cortisone will be recognized in an emergency.



medic alert emblem

An application for a medic alert emblem may be obtained by writing: 174 St. George St., Toronto, Ontario.

There's a lot to learn about cortisone, isn't there?

It's one of the most complex and useful drugs.

The last word of advice — please keep in touch with your doctor — let him know when things aren't quite right. Be sure to keep all your appointments. And if you have questions at any time, don't hesitate to contact him or your local public health nurse. ♣

Here is a place to write the directions for your dose of cortisone.

Dosage. _____ mg. (_____ mg pills × _____.)

Time: _____

(Circle the correct one)

Every day

Every second day

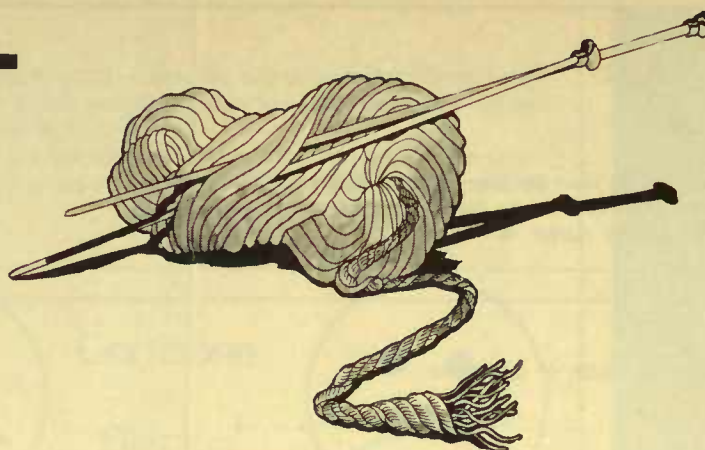
Here is a place for your questions.

Acknowledgment: The author wishes to express appreciation to Margaret Colquhoun of the Drug Information Centre, University Hospital, London, Ontario for her assistance in the preparation of this article.

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Patient Teaching as a CURRICULUM THREAD

In the past, the philosophy, theory and practice of patient teaching, although implicit in most programs of nursing education, have not received the emphasis they deserve. What follows is an explanation of what one school is doing to prepare its graduates to become health educators in the fullest sense of the word.

Jean Jenny

Rapid changes in health care in the last few decades have encouraged nurses to revise their ideas about their so-called "professional role," to include not only caring for the sick and assisting with the cure of illness but also helping people become capable of self-care. Peplau suggests that the "shift is one from traditional mother-surrogate activities to more educative nurturing ones."¹ With this broadening of nursing's scope to embrace such concepts as health maintenance, health attainment and regaining of health,² the need for increased emphasis on the knowledge and skills of patient teaching becomes painfully evident. Unfortunately, studies have repeatedly shown that patient teaching is still regarded as secondary or unimportant to both nurses and patients.^{3,4} Nurses claim they don't know what or how to teach patients and repeatedly fail to perceive or utilize opportunities for patient instruction. Patients admit they don't ask nurses for help because they don't know what to ask, don't know how to ask, and do not perceive the nurse as the appropriate source of health information.⁵ Numerous studies of patient compliance indicate that

often the instruction that patients do receive is inadequate, since compliance rates are dismally low.⁶ In short, patient teaching, while embodied in the new nursing practice acts and standards, is honored more in the breach than observance, and needs more than lip service to become a recognized and sought after component of modern nursing care.

There are many reasons why nurses have been slow to accept the challenge of health teaching. Some of these reasons — the lack of administrative provision (staffing) and incentive (money), for example — are beyond the scope of the nursing educator. Others, however, relate more closely to confusion about the role of nurses as teachers and the development of the necessary skills and attitudes. As Redman points out: "One must be very secure to give up the satisfaction that comes from giving services and begin to derive it from teaching. The latter, which involves guiding patients through slow, fumbling, half-hearted efforts to do something for themselves can be fatiguing and trying for the nurse. In addition, nurses who undertake teaching programs with patients must be willing to be concerned about them and to work

through their learning programs with them. Again, this is a kind of nursing very different from just giving essential physical care and following physician's orders.⁷

As a tool of nursing practice, teaching belongs in the curriculum. That is why the focus of the medical-surgical nursing course during the second year of our three-year baccalaureate program for registered nurses is on patient teaching. We have structured the entire second year program around four major themes:

- the nature of man
- human society
- health-disease continuum
- nursing.

Through each of these, patient teaching forms a continuous thread. Student assignments explore the philosophy, theory and practices of patient teaching, leading up to preparation of a program of patient teaching for a chronically ill patient.

We agree with Malkemes that "resocialization" is a major challenge in the transition of a diploma nurse to baccalaureate level of practice, and must involve "a change in her self-concept whereby she sees herself as the provider of direct care to clients rather than a

provider of services to institutions and agencies".⁸ Patient teaching seemed to be an ideal vehicle for exploring skills such as independent functioning, accountability, communication skills, interpersonal competencies, patient assessment and even nursing process itself. Planning and implementing patient teaching constitutes a skill that is an integral part of nursing in whatever milieu is practised. It is also an indispensable ingredient in the progress of any patient from dependent care receiver to knowledgeable participant in his care. Through experience we have also found that for the majority of our students it represents a challenging, unexplored and satisfying territory of nursing practice.

In structuring the content, we followed the principles of process learning described by Redman⁹

enjoy the opportunity for public speaking and display surprising aptitude for group teaching. Most are apprehensive about the verbal presentation but show significant improvement the next time around. By the end of the first semester each student is expected to have an understanding of the teaching/learning process, recognize the obstacles to learning, identify nurse attitudes which affect her teaching, be able to name the goals of patient teaching, and identify the information and experiences needed by patients at various stages of the health-illness continuum. We hope that by then the student will be prepared to develop a philosophy of patient teaching and will have a general theoretical background providing a basis for the next assignment. Films such as "Mrs. Reynolds," "Walter Krolick" and "Best

learning needs. Each student rehearses with the instructor what she feels is needed and a written guide is frequently left with the patient. We have had occasional feedback the following week from indignant physicians who were obviously taken aback at their patient's knowledgeable queries and concerns. In one instance a physician was annoyed at the student's "presumption" but could not find fault with the agenda which the patient produced.

Our students have evaluated the exercise in very positive terms: for many it has been their first real venture into the psychosocial realm of nurse/patient interaction. They agree that having actively engaged in the process of preparing a program, they are better able and more motivated to re-enact the process and to take the initiative in helping the patient to identify his concerns.

In summary, we believe that patient teaching, as an art and skill, exemplifies the advocacy model of nursing that our program attempts to portray, and represents a challenge for future nursing: *"the highest level of care is self-care, and that is a more difficult challenge for health professionals than providing the care themselves."* ♣

One
Reception of
information through
symbolic medium

Two
understanding
general
principles

Three
particularizing

Four
acting

Steps one and two are covered in the work of the first semester; steps three and four in the second semester. Students are responsible for one written assignment in each semester, based on their choice from among five or six pre-selected topics. When the students have chosen their topic they work together as a group — researching the topic, composing the presentation, presenting it orally during a three-hour class and fielding class discussion.

In the first semester the topics include:

- determinants of patient compliance
 - teaching content appropriate to patient situations such as transfer from ICU to the ward
 - pre-operative patient preparation
 - post-operative patient teaching
- (The last two topics are handled separately because of the volume of literature available. They include concepts such as anxiety, worrying, surgical and psychological complications).
- blocks to effective nurse-patient communication
 - teaching approaches

(This includes developmental level of the patient, structured vs. unstructured teaching, formal vs. informal teaching, self-help groups and the needs of the patient's family).

A bibliography of from twelve to twenty entries representing the best of the literature on that subject is available for each topic and questions with which the assignment must deal reflect this material. Some of the students actively

Damned Fiddler from Kaladar to Calabogie" are used as a basis for discussion of concepts such as values, attitudes, lifestyle, roles and expectations, all of which contribute to the theory of patient teaching.

For the next assignment, each student selects a topic from a list of six or seven chronic diseases, (diabetes, hypertension, arthritis, etc.) and implements the nursing process in the preparation of an appropriate teaching program. Students research the nursing literature, interview patient groups, contact specialized nursing staff and relevant national associations to obtain samples of available teaching literature. In their class presentation, the groups are encouraged to make use of role playing to show exactly how they would offer some of the material. The assignment specifically requires consideration of how much pathology is necessary and how it is to be offered; this seems to be the most difficult of all the content for nurses to deal with satisfactorily. Psychological and social effects of the disease are explored, a process which activates considerable empathy on the part of the students. Methods of evaluating the patient's learning are suggested.

To date, our major difficulty has been the inability to present each of the programs to a group of actual patients. In spite of this, the students do demonstrate, during the course of their clinical experience, an increasing concern for their patients' perception of the situation. Every student, in differing degrees, becomes conscious of the patient's

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HAVE PATIENTS— WILL TRAVEL



Doreen Scott
Malcolm McKenzie

It was a beautiful, sunshiny day in Alberta last May. The bus door yawned wide open, an invitation to its waiting passengers. Suitcases stood in rows like soldiers on parade; beside the suitcases were shopping bags containing powdered drinks, facial tissues and bags of cookies. Bright sunlight reflected off the chrome of the freshly washed bus, adding to the air of anticipation.

When he looked at the scene in front of him, George Crowhurst had to pinch himself to believe that it was not a dream. It was true: he was about to embark on a 1600-mile round trip with 27 mentally handicapped patients that would take them from Ponoka, Alberta, over the Rocky Mountains to Victoria, B.C. and back again. Months ago, when he had first mentioned his dream to fellow workers and administration, reaction had been mostly negative. "You're crazy," some of the staff had said. "It's too far, too risky." But management at the Alberta Provincial Hospital had said "go ahead" and now here he was.

Altogether, 36 passengers boarded the bus — 27 patients and nine staff, including social worker Crowhurst. The invitation had made it clear that patients were expected to dig into their own pockets to help meet the expenses of food, lodging and transportation along the way. Friends of Alberta Hospital helped some of them and the Women's Auxiliary of APH came to the rescue of the only patient who had neither

resources or relatives to turn to. The Ponoka branch of the Royal Canadian Legion was able to see that one veteran made the trip.

As they boarded the bus, George recalled the work that had gone into planning this first out-of-province trip for the patients at our psychiatric facility. He and Eva Balerud, geriatric rehabilitation coordinator, had spent many hours in discussion with other people behind the scene before selecting the patients and staff that would benefit the most from the trip. There were consultations with nursing service and administration, doctors, coordinators and head nurses. Then, letters and phone calls to notify them of the trip and to ask permission for "Uncle Joe" or "Mother" to come along.

After that it was time to contemplate the logistics of moving 36 people from one place to another and back again — transportation, meals, accommodation, etc. Fortunately, an Edmonton travel agency took over at this point — hired a bus and arranged for the accommodation that would be needed each night along the route. Their final destination, Victoria, was chosen because it is the home of "The Priory," a hospital run by the Juan de Fuca Society and famous across the country for its human approach to the aged female population that lives there. Many of the staff had already had the chance to see the "Priory Method" in action and looked forward to learning more about this important concept.

As patients and staff boarded, the excitement grew. Feeling tension



building up, Clara, a lady with a healed broken hip, decided she couldn't take it, and announced she wouldn't go! "Won't go?" said George, and off he went to coax her onto the bus with all the charm and experience of twenty-five years of psychiatric nursing and social work behind him. Clara went and still talks about her Victoria holiday to this day.

Our director of nursing, Mary Abt, geriatrics-rehabilitation coordinator Eva Balerud and myself, along with other members of staff gathered round to give the expedition an encouraging sendoff. Some of the staff who were waiting to get on the bus were not without some misgivings: the seven-day trip represented constant involvement and responsibility for the patients in their care.

It is one thing, to work a five-day week on a ward where many types of elderly people are housed, but quite another to live with them on a twenty-four hour basis! As the staff members in charge they would be expected to live in the same motels, even sleep in the same bed in some cases, assist with feeding, toileting, dressing as well as helping the patients to enjoy the holiday.

Malcolm McKenzie, R.N., R.P.N. was to be their senior nurse responsible for medications and supervising all the "tender loving care," as well as looking after the patients assigned to him. As head nurse on our Dawnview Unit, he had 15 of his 44 patients with him on the holiday! His tasks were varied, his days long and nights short since his charges did not want to miss a thing and so were up with the birds!

The seven other staff included Dale Wallace, a psychiatric student nurse, Darcie Wiggins, certified nursing



assistant, four aides, some with many years of experience at our hospital and, last but not least, Roy Wilson, R.P.N., activity coordinator, whose flair for entertaining was greatly appreciated.

Role reversals took place as the older patients tended to care for the younger staff, even to the point of peeking under the shower curtain at their motel, and asking "Are you alright, Mark?" Arising in the morning, patients hurried to wake the staff, perhaps deciding that "turnabout is fair play." Basically, patients handled physical problems such as motion-sickness, and fatigue better than staff members, most of whom were seasoned travelers.

There was much caring and concern for one another. When the bus made a rest stop, members of the group stayed together in the eating area of the restaurant. Members of the public tended to regard our group as a unit — senior citizens from Alberta. Even bus driver Gordon Meyer of Calgary became a part of the group, assisting whenever and wherever he could to give our patients the best possible holiday, for some the only holiday they ever had. It is worth noting that one of our isolated, withdrawn ladies, personally thanked Gordon on her return for his driving throughout the trip and another presented him with a small token of appreciation from the group.

Throughout the trip, most patients ordered and paid for their own meals. The cost of these meals astounded most of them and resulted, on a number of occasions, in reluctance to order

anything at all to eat. Incredulous of the prices, many of them looked for bargains on the menu. One, obviously very shocked, even swore softly on reading the prices in one restaurant.

There were many memorable sights and events on the trip: we share memories like the tour of the Butchart Gardens, ferry-boat rides, and mountain silhouettes of jagged, snow-capped peaks. The Lion's Gate Bridge viewed from Prospect Point in Vancouver's Stanley Park was another highlight.

Best of all, though, was the warm welcome that waited for the group at The Priory. The welcome mat was out and an entertainment program was enjoyed by Priory residents and members of our group alike.

During the trip, arrangements had been made for members of the group to visit with former staff members who now live along the route from Ponoka to Victoria. These meetings were poignant reunions for both patients and staff and there were few dry eyes when the time came to say good-bye again.

In fact, when the trip was done, the only criticism that was heard was that a week was too short a time for this adventure. Everyone returned to the hospital a little travel-weary and many felt that an extra day to rest up should have been added to the stay in Victoria before starting the return trip.

Pictures taken by the staff during the trip have brought the holiday back to life for the residents, many of whom were viewing pictures of themselves for the first time in years.

"I look and feel ten years younger," was the comment of one of the group upon returning home to APH. There was a sparkle in his eyes as he said it, and a lift to his step! All of the patients

have now received individualized pictures of their holiday which they keep on their bedside lockers. On some units, picture groupings posted in conspicuous places help patients to re-live their trip in memory over and over again and are a constant reminder of this exciting event in their lives.

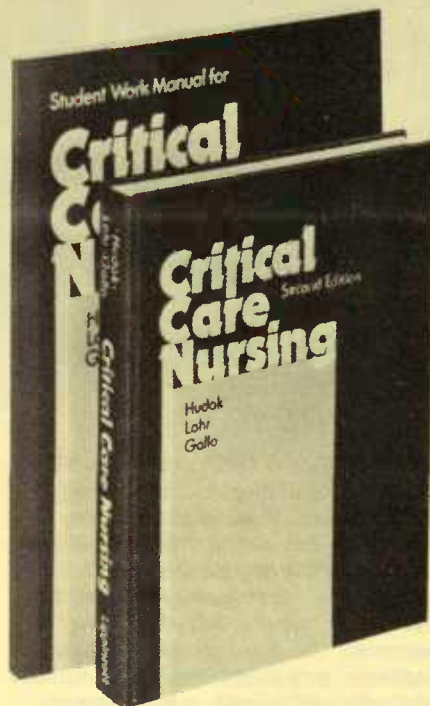
Malcolm and George are busy planning a similar trip for 1978. Their incentive comes from the little things — things like the closer relationship that has developed between patients and staff since the last trip, the fund of warm memories that we all share, and the slow, tender smile of an elderly gentleman who shows his holiday pictures to one of us. Most important of all, though, are the requests that have come from members of the first group to "go somewhere again" and from those who were left behind, asking "can I go too?"

Doreen Scott and Malcolm Mackenzie are co-workers at Alberta Hospital in Ponoka, Alberta where she is patient services coordinator and he a head nurse on the Dawnview Unit.

Doreen Scott is presently enrolled in the Master's program at the University of Alberta. She is a graduate of the Calgary General Hospital and received her R.P.N. from Alberta Hospital and the B.Sc.N. from the University of Alberta.

Malcolm Mackenzie received his R.N. from Canterbury District Hospital in Canterbury, Kent, England, and his R.P.N. from St. Augustine's Hospital in Canterbury. In Canada, he received a nursing management and patient care diploma from Red Deer College in Red Deer, Alberta.

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Family-centered care

More than a cliché



Who is it the public health nurse assesses and treats when she visits a home? Is it only the individual who has been referred to her for care, or does she also assess the total family unit? This was one of the questions I explored in a recent study of public health nursing. What follows are some views expressed by nurses concerning their practice of family-centered care and their perception of ways this care might be improved.

Public health nursing or community nursing was traditionally claimed expertise and responsibility for care of the family. Because the public health nurse provides service within the home, she is in an excellent position to view the problems and progress of families and of individuals within their family setting. We pay lip service to the concept of family-centered care in community nursing but do we practice what we preach? This is what I wanted to find out.

When asked the question "Is family-centered care necessary," three public health nurses replied:

It's the only way to give care and to help people change.

When a family is involved with the care it seems more dynamic — if one member is changed they all change at least some.

It's much more satisfying — you can be more helpful — we do family-centered care but we could do it more consistently.

These three nurses were among 20 public health nurses I observed during a research project developed to analyse the application of family-centered care in public health nursing visits.

To gather data for the project, I accompanied each of these nurses on one home visit. Only families which had received at least two previous visits in the last six months and whose members spoke and understood English were included in the study. In addition, an interview-schedule was used to explore the nurses' views and their perceptions of family-centered care. This supplemented my own observations made during the home visits.

The study defined family-centered care as:

"Care given to the total family. While the care may be focused on one member the public health nurse will be aware of the effect of the problem on the family and the family's effect on the problem. The focus of care may change from one individual to another as the needs change. This implies that the needs of all members must be assessed with the aim of health promotion and early case finding."

Using this definition as a standard, I asked the nurses to describe what they thought family-centered care was. Not surprisingly, their definitions also emphasized the family unit and the interrelationship of problems. For example, some defined it as:

Focusing on the problems of the patient, but also on how they affect others and how others affect the problems.

Looking at all the family needs and meeting them if you can swing it.

Taking the whole family into consideration — physically, psychologically and socially.

Assessing patterns of the family, then zeroing in on most appropriate person — if you can help that person the whole family will change. We must deal with what the family sees as the problem.

In general, the way the nurses viewed family-centered care appeared to be a direct reflection of their own experience in providing care to families. In other words, the nurses put into practice their own definitions of family-centered care.

When asked if they felt able to provide family-centered care to the family in the study, 13 of the 20 nurses stated that they perceived the care given as family-centered. Sixteen of these nurses stated that they interpreted their care as individually centered at first but that this focus quickly expanded to include other family members. Nurses explained this way of entering a home:

The way to get in is by the individual, then expand.

You deal first with the person referred.

If referral is for an individual, then you must deal with that individual first. If it is a family that is referred, and this happens when there are behavioral problems or problems of parenting, then you immediately interpret care as family-centered.

All the nurses thought that family-centered care should be provided.

Concern for families

During the home visits, the majority of nurses showed concern for more than one family member and displayed an awareness of the interweaving of problems, personalities and environment. Evidence of this was observed in a number of situations. Examples of nurses' assessment of family responses were:

- A nurse assessed a family's response to their preschool child with Down's Syndrome.
- A nurse stated that a father did not accept the fact that there was a behavior problem.
- A nurse remarked that the discipline of the son was very inconsistent — mother gave in, father was strict.
- A nurse talked very kindly but directly to both parents about the need to "talk out" their feelings about a grossly retarded child and also about genetic counseling.

Some of the nurses felt it was important to talk with all family members stating:

I have no hesitation in saying to the family that I would like to see the whole family. The father appreciates being included — often takes time off to keep this appointment.

Paternity leave means that we see more fathers.

I have had more success in families when I have had both parents involved in the care.

On the other hand, many found it hard to involve all other family members, particularly the father.

While the focus is on the whole family, I seldom see the father.

Usually it's just the preschool children and mother — the father is at work, the children at school.

Often the husband doesn't know we are interested in him — he thinks the nurse is there to see the mother and baby — this is mother's work.

One nurse who had visited a mentally ill lady for some months had talked with the son and realized his concern about his mother's illness. However, the nurse had not met or talked with the husband even though she had commented that the husband "must be frustrated at times."

Family assessment

During the interview, I asked the nurses to describe how they assessed families. Eleven of the 20 nurses indicated that at first they focused on the referred person, the reason for visiting or the presenting problem and then, as they listened, their focus widened to include other family members and potential problems.

Five of the 20 nurses said they started their assessment by finding out how the family saw the problem. One nurse remarked that often the family needed more help than the referred patient, especially when terminal illness was involved. Four said they assessed "by listening and observing."

I usually assess strengths — note if reinforcement is positive.

Find out how they cope with stress and change.

Observe the interaction — help them identify the difficulty.

May look at dissension in family — sometimes one member wants help, but others don't — this is common where there is an alcoholic problem.

I was interested also in knowing what specific factors nurses perceived as being helpful or inhibiting to them in giving family-centered care. The nurses were able to identify six factors that helped and six that inhibited. The number of nurses making each type of comment is noted.

Factors that help

1. *Work itself.* Since public health nursing encompasses so many programs, e.g. home visiting, prenatal classes, parenting groups, school work, liaison between hospital and community etc., the nurse has ample opportunity to meet various family members. (Ten nurses).
2. *Other workers.* Family doctors, nutrition consultants, interpreters and other helping agencies refer families to the public health nurse. (Ten nurses).
3. *Nursing team.* Supervisors and administrators who encourage this type of service (family-centered care) are helpful. (Eight nurses).
4. *Education.* Basic nursing education, inservice education and experience is helpful to prepare for this type of work. (Eight nurses).



5. *Time.* The four-day week¹ permitting early evening visits was mentioned three times, and "flexible hours"² was mentioned three times. One nurse stated that although it wasn't often, she sometimes made evening visits and realized this helped. Another said she didn't often make evening visits but she had given out her telephone number and had frequent calls at home. (Eight nurses).

6. *Parent groups.* This was a factor that helped both the nurse and parents become aware of the importance of family-centered care. (Five nurses).

Factors that inhibit

1. *Time.* Three-quarters of the nurses (15) saw that time was an inhibiting factor. This mainly referred to the fact that many public health nurses work 8:30-16:30. Some said they made evening visits if really necessary but this was seldom done. One nurse said that what was needed was a balance of structure and non-structure with less rigidity. Two nurses said they did not like to make evening visits.

2. *Patient motivation.* Nurses talked about the difficulty in motivating people. One nurse mentioned that when both parents worked motivation was especially difficult.

3. *Family living arrangements.* Six nurses mentioned that on some types of visits, it was difficult to give family-centered care. Two nurses explained that in one case, a mother did not want the nurse to know of her common-law relationship because of housing restrictions and allowances; consequently, the nurse could not talk to the father.

4. *Nurse-centered problems.* The nurse herself sometimes finds it difficult to give family-centered care. This may be due to lack of confidence, lack of experience, too big a case load or too many crisis visits. For example, sometimes the nurse is hesitant to make an appointment to see the father or to ask him to come home from work early.

5. *Language problems.* This was mentioned by three nurses.

6. *Other.* One nurse felt that the current societal emphasis on independence inhibited family interaction and family-centered care.

1. In one health department, 23% of the nursing staff (22 staff nurses and two supervisors) were working a four-day week (Monday-Thursday or Tuesday-Friday). Arrangements were made for a nurse to take emergency calls for nights and weekends, a service that was provided by the supervisory staff at the time of this study.

2. In the same health unit, flexible hours permitted selected staff nurses to arrange the time of their eight-hour day to carry out services. When the study was made, 12 nurses were working flexible hours in one agency. Nurses working a four-day week could also have flexible hours in this agency.

My observations

I was highly encouraged by what I observed during the home visits. Not only did the public health nurses in this study show that they believed family-centered care should be implemented, they demonstrated this belief in many of their interventions. For instance they demonstrated their assessment of health problems in many ways. In one case, a young mother told the nurse that her infant was very constipated. The doctor had been consulted twice about this problem and had made an appointment for the infant at Sick Children's Hospital. On inquiring about the feeding, the nurse was assured by the mother that the baby was being fed Similac.* In discussing formula preparation, the nurse asked to see the can of Similac to use as a teaching aid. She noticed that the label was not the usual color and realized that the baby was being given Similac with iron in error. The mother agreed that in addition to the constipation, the baby's stools were very dark. The nurse then explained the relationship of these symptoms to iron consumption.

It is interesting too that while many of the nurses were interested in and concerned about more than one family member, they sometimes found it unrealistic or unnecessary to talk with and assess all members. When unable to talk with some members of the family, nurses often enquired about them and frequently provided health teaching and counseling indirectly, that is, via another person. An excellent example of this occurred when a nurse visiting a new mother spent much time talking about the husband's diabetes and helped in planning menus following the prescribed diet. This nurse made plans to contact the diabetic husband at a later date.

The nurses' identification of factors that helped or hindered was often confirmed in the home visits. For example, time was seen as a hindrance when a family with a new baby was discharged from care after two visits even though the young mother was described by the nurse as immature. This mother was returning to work and the nurse felt it was too difficult to plan the evening visits that would have been needed. However, another nurse who worked flexible hours had no hesitation in initiating an early evening visit to meet with a couple to discuss the care of an elderly parent.

Recommendations

What are the ways in which family-centered care can be improved? From this study of 20 public health nurses, it is evident that there is room for improvement in this area of our practice. To this end, I would suggest that:

- public health nurses focus on direct assessment of families and promote the direct involvement of other family members in planning and implementing care.
- public health agencies review their policies concerning working hours and be aware of those factors that nurses see as helping or inhibiting them in giving family-centered care.
- agencies evaluate the purpose and method of recording care in order to bring about improvements in records. It was noted that many existing records did not adequately show either the amount or quality of nursing service rendered.
- in the preparation of nurses, increased emphasis be given to developing skills in motivating families and working with groups, and in assessing individuals and families; also that attention be given to student's skills in recording concisely and accurately.
- further research into the application of the concept be carried out. Suggested areas are: the effect of organizing service by team or by geographical district, the effect of working a four-day week or flexible hours; whether family-centered care is more likely or less likely to be given in relation to a specific program area such as maternal-child or mental health.

Conclusion

There could be no mistaking the very real way in which the concept of family-centered care was being applied in practice, with a very full appreciation of all that it implied as well as the support these nurses were receiving from the agencies they worked for.

In addition, the nurses were articulate about their belief in family-centered care. One nurse's comment in particular seems to summarize their enthusiasm and confidence:

We are doing family-centered care but we need to do more. It's fun and more satisfying because we have more successes. The more we do the better the families will be. I think we should start with beginning families or maybe before. It's going to make a difference to these children's families — they're learning group skills early, sharing, caring, etc. — family-centered care is health promotion.



Rosella Cunningham, B.Sc.N., M.P.H., is an Associate Professor, Faculty of Nursing, University of Toronto. She has had many years' experience in the public health nursing field and has made a number of studies relating to public health nursing visits. This article is based on the report of her most recent study: *An Analysis of the Application of The Concept Family-Centered Care in Public Health Nursing Visits (Faculty of Nursing, University of Toronto, 1976)*. The complete study is available on interlibrary loan from the CNA Library.

*Similac is a registered trademark of Ross Laboratories, Division of Abbott Laboratories, U.S.A.

Sixty percent of persons dying from acute myocardial infarction do so before reaching the hospital. The majority die as a result of lethal arrhythmias and have hearts that are still "too good to die." With the development of the techniques for CPR and the use of the external defibrillator in the early 1960's, the in-hospital death rate from acute MI has now been reduced from approximately fifty percent to fifteen to twenty percent. The next major attempt at reducing the overall death rate from acute myocardial infarction must be an improvement in the pre-hospital care of the patient. Preliminary evidence from the United States has shown that an effective emergency cardiac care program consisting of widespread CPR training in the community and advanced life support systems can reduce the prehospital death rate from myocardial infarction by approximately thirty percent.

CARDIOPULMONARY RESUSCITATION (CPR)

Step-by-Step

Sandra LeFort

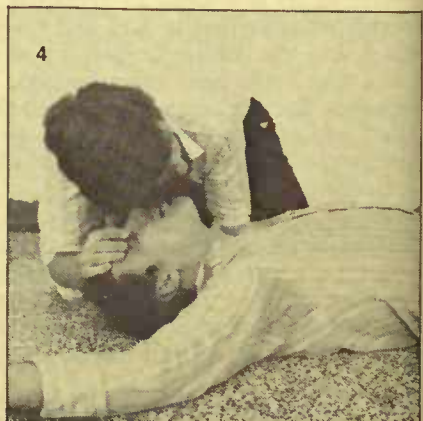
The Canadian Heart Foundation has recently adopted standards established by the American Heart Association (JAMA, 1974 227, no. 7) for the performance of CPR in Canada. These standards have now been adopted by all provincial heart associations and a number of other health-related agencies. The standards involve a rigid training program in Basic Life Support CPR including thorough practice sessions on recording manikins.* They also include both written and performance testing on: one and two person unwitnessed cardiac arrest, witnessed cardiac arrest (in certain cases), obstructed airway and infant resuscitation. Certification of proficiency is given at the Basic Rescuer, Instructor, and Instructor-Trainer levels.

In most provinces, programs have already been developed to extend CPR training to specific target groups. In Ontario for example, doctors, nurses, hospital staff having patient contact, dentists, ambulance attendants, policemen, firemen, first aid instructors and high risk industrial workers are priority trainees. Eventually families of cardiac patients and the general public will be given the opportunity to learn the new standards. In the future, standards for the implementation of Advanced Life Support systems will be introduced.

Cardiopulmonary resuscitation is a fundamental skill for everyone involved in patient care. As a nurse, you have probably witnessed at least one cardiac arrest. Some of you may recall many less than adequate resuscitation attempts — poor assessment, faulty technique, confusion, panic and fear that, in too many cases, seems to be part and parcel of such a crisis.

The following step-by-step approach to Basic Life Support CPR is based on the New Canadian Heart Foundation Standards. It is meant to show you the "how to" of basic CPR using the correct sequence of maneuvers. **It is not intended to be a substitute for attendance at the provincial programs or inservice education courses now being offered across the country.** These programs provide an opportunity for you to learn about "Prudent Heart Living", including risk factors and early warning signs of heart disease and to practise and perfect your CPR skills.

EFFECTIVE CPR SAVES LIVES. MAKE IT YOUR RESPONSIBILITY TO KNOW HOW.



* Never practice CPR on a live person.

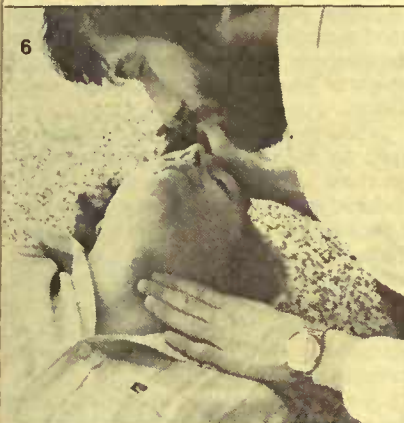
UNWITNESSED CARDIAC ARREST PROCEDURE

One rescuer and two rescuer

5



6



7



8



If you discover an individual who appears to be unconscious, act promptly. You may be in a position to save a life, IF you recognize the need for action, assess the victim, and perform the steps of CPR effectively.

1. The first step is to establish the unresponsiveness of the victim. The best way to do this is to "Shake and Shout". Shout repeatedly "Are you alright" loudly into the victim's ear, shake him briskly by the shoulders and tap his face.

2. Position the victim flat on his back if he is slumped over, crumpled up or lying face down as is often the case in sudden loss of consciousness.

3. Continue to "Shake and Shout." Call for help if the victim does not respond within a few seconds in the hope that someone will assist you. Although you need to act quickly, you must take 7-15 seconds to establish the unconsciousness of the victim. This amount of time is necessary for you to assess that this person is unconscious and not just asleep or in a faint. You are looking for a reaction from the patient — a facial expression, a movement. Look for this.

The key to checking the consciousness level, then, is to take your time and use the 7-15 seconds. If the victim is asleep, your attempts to arouse him will be successful.

4. If you cannot arouse the victim, kneel close to his head and **open his airway**. Use the head tilt method by placing one hand under his neck and the heel of your other hand on his forehead to hyperextend his neck. Remember that you are trying to keep the tongue from falling into the back of the throat and obstructing the airway, so don't be afraid to fully hyperextend the neck of an adult victim. As shown, the victim's ear lobe should be in line with his chin.

Now that the airway is open, **check for breathlessness** by placing your ear over the victim's mouth. **LOOK** at the chest, **LISTEN** for breath sounds and **FEEL** for air movement. Think about what you are doing and take 3-5 seconds for this assessment.

5. If there is no sign of breathing, pinch the victim's nostrils tightly with your thumb and index finger while still keeping the flat of your hand on his forehead. Open your mouth wide, take a deep breath, make a tight seal around the victim's mouth and **give four rapid ventilations**. Do not wait for the lungs to completely deflate after each breath. Your goal is to get as much oxygen as possible to the victim so be forceful and rapid in your ventilations. Be sure you have a tight seal over the victim's mouth and the nostrils are tightly pinched.

If your breathing efforts are being effective, you should be able to:

- feel air going into the victim's mouth;
- feel some resistance in the victim's lungs;
- feel your own lungs emptying;
- see the rise and fall of the victim's chest and abdomen.

In actual practice, rescuers often under or over-ventilate the lungs — both of which cause problems to the victim.

Under-ventilation does not provide enough oxygen to the victim while over-ventilation can force air into his stomach. Knowing how forcefully you have to breathe for the victim is a matter of practice and more practice!

6. **Check for the carotid pulse.** This is a reliable sign of whether or not the heart has arrested and blood is circulating. Slide your fingers into the groove or hollow beside the Adam's apple and press lightly, using the flat of your fingers to feel for the pulse. **DO NOT RUSH.** You have 7-10 seconds to find a pulse, so look for it if you don't find it immediately. A good way to pace yourself if you tend to rush is to count the seconds out loud and think about what you are doing. Remember that you must never begin cardiac compressions on a pulsating heart, no matter how weak the pulse, so be absolutely sure!

If you do feel a pulse, even a very weak one, during your assessment, do not begin cardiac compressions. Continue breathing for the victim at a rate of once every five seconds (12 times per minute). Continue to monitor the pulse.

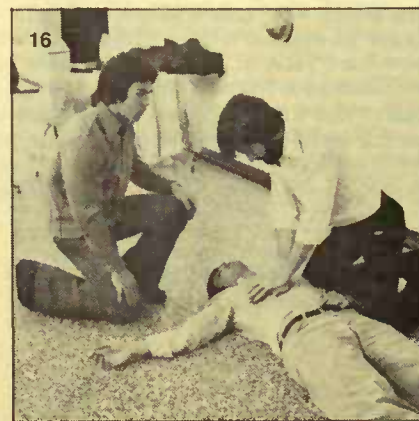
If the victim begins to breathe spontaneously while you are doing rescue breathing, turn him on his side and continue to observe him until help arrives.

7. Absence of the carotid pulse and breathlessness indicate cardiac arrest. If you cannot find a carotid pulse after 10 seconds, **initiate external cardiac compressions**. This consists of the rhythmic application of pressure over the lower third of the sternum to squeeze the heart between the sternum and the spine. The blood flow resulting from external cardiac compressions is, at best, only 1/4 to 1/3 of normal, so it is important to be as effective as possible.

With the victim flat on a hard surface, the first step is to **find the landmark** for compression — the lower third of the sternum above the xiphoid process. Placing the middle finger of the right hand (in this case) in the notch at the top of the sternum, run the fingers of the left hand along the ribs to the notch in the center of the chest. This is the xiphoid process. Place your middle finger on the notch and lay your index finger beside it, across the sternum.

8. Lay the heel of your other hand over the sternum, right beside the index finger. This is your landmark — the lower sternum, one finger above the xiphoid process.

It is extremely important that you find this landmark every time you initiate compressions after giving ventilations. If you do not, the danger of compressing the xiphoid process and causing laceration of the liver is great. Find this landmark every time.



9. With the heel of your right hand over the sternum, place the heel of your left hand directly over and parallel to the right hand. Only the heel of your hand should touch the chest. The fingers must be slightly elevated, to prevent them from encircling the chest and causing possible rib fracture.

10. If you find it difficult to keep the fingers lifted, you can interlace them for better control, as shown. The important thing is that your hands are parallel and that only the heel is in contact with the chest.

11. Position the rest of your body so that:
a) your shoulders are directly over the victim's sternum and

b) your arms are straight, not bent at the elbow. This position will allow you the greatest effectiveness of compression with minimal strain on you.

12. Once you have the proper landmark, hand position and body position, **compress the sternum 1 1/2 to 2 inches** by using the weight of your upper body to push straight down.

You must be precise in the force you exert on the chest. If you undercompress the chest, using too little force, you will not succeed in completely emptying the heart. If, on the other hand, you overcompress the sternum, there is a chance of cardiac contusion and tamponade. So, know what 1 1/2 to 2 inches looks like. It takes practice.

Remember to push from the back and shoulders and to lock your elbows when compressing the sternum.

13. Having compressed the heart, **release the pressure** to allow the chest to return to its normal position. Do not lift your hands off the chest or change their position in any way. Just release the weight of your body so that the sternum can rise completely. Allowing the sternum to rise only part way is a common error so watch for this.

A complete compression consists of these two phases: the down stroke and the release. Both must be done correctly to produce efficient circulation. Timing is important. It should be a 1:1 push and release cycle — not a sharp pressure and a long release. You should establish a smooth motion of "compression-release," "compression-release," and repeat this cycle 80 times/minute.

14. As a single rescuer, you must alternately compress the chest and breathe for the victim at a ratio of **15 compressions to 2 ventilations**. Once you have firmly compressed the chest 15 times, lean over to the victim's head, open the airway and give two quick full breaths. This cycle of 15 compressions:2 breaths must be done in 16-17 seconds to maintain adequate circulation. Remember that any interruption in compressions results in a drop in blood flow to zero, so be as quick as possible.

The best way to pace yourself is to call the mnemonic (counting device) out loud. For the single rescuer, count out the compressions in this manner:

one and two and three and four and five and one and two and three and four and ten and one and two and three and four and fifteen (lean over and give two full breaths).

1. Immediately after giving the breaths, find the landmark for compressions and begin again. Pause after one minute and every four-five minutes thereafter to check pupils, breathing and pulse to determine if your rescue action is being effective. Once you have initiated CPR, **never stop for more than 5 seconds.**

4. Let's assume that someone hears your call for help and comes to offer his assistance. If he has been trained in CPR under the new Canadian Heart Foundation standards, he will say, "I know CPR, can I help?" Your response will be "Breathe."

5. It is understood at this point that the helper will open the airway and give one full breath to inflate the victim's lungs. In the meantime continue your compressions as before, counting out loud as in step 14. As soon as you feel the lungs inflate fully, change your count to: *one-one thousand; two-one thousand; three-one thousand; four-one thousand; five-one thousand; (and repeat).*

6. With two rescuers, you must slow down your rate of compressions to 60 per minute. Remember that as the first rescuer, you are the boss; the helper follows your instructions.

8. Once two rescuers are working on a victim, **the ratio of compressions to ventilations changes to 5:1.** On the upstroke of each fifth compression, the second rescuer will inflate the lungs with one full breath.

Never pause in your compressions when you feel the lungs inflate. This is a common error but one which you should avoid. If your timing is correct, the lungs should inflate when you release the pressure on the chest. You will feel a greater resistance as you compress down when the lungs are filled, so you will need to compensate for this to achieve a depression of 1 1/2 to 2 inches.

The key point is not to pause. Your job is to keep a rhythmical cycle of compressions.

9. After a while you may feel very tired and wish the second rescuer to take over compressions. Tell him to do so by saying: *five-one thousand ... next ... time ... change... on ... three...*

You must keep the same timing as the original mnemonic. Each word should take one second.

As soon as the second rescuer hears this, he will give one ventilation as usual, then shift his position so that he is over the victim's chest. Then he will place the middle finger over the xiphoid process, lay his index finger beside it and have the heel of his hand ready to take over compressions.

10. As soon as you say "three-one thousand," move your hands from the chest and prepare to breathe for the victim. The second rescuer places the heel of his hand over the lower sternum and continues compressions. He carries on saying the count: "four-one thousand, five-one thousand, etc." You will ventilate on the upstroke of five.

11. Check the pupils, pulse and breathing of the victim at least every 4-5 minutes.



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All photos by Studio Impact, Ottawa.

WITNESSED CARDIAC ARREST PROCEDURE



1. If you see an individual suddenly clutch his chest, slump in a chair, fall to the floor and lapse into unconsciousness, you may be witnessing a cardiac arrest. On the other hand, the person may be having a stroke, seizures or a blackout spell. But whatever the reason, this person needs assistance.



2. As in the unwitnessed arrest procedure, the first step is to **establish unresponsiveness** of the victim by "Shake and Shout." Take 7-15 seconds to assess unconsciousness.

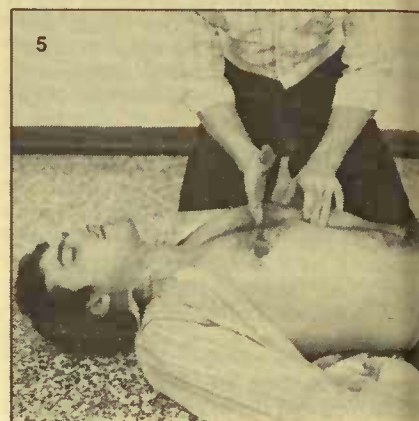


3. If there is no response to your attempt to arouse the victim, **open the airway** using the head tilt method and check for a carotid pulse. Once again, you have 7-10 seconds to search for a pulse. Look for it if you do not find it immediately.



4. If the pulse is absent, the victim is in cardiac arrest. A **precordial thump** delivered with your fist over the midsternum within one minute after cardiac arrest may be enough to generate a small electrical stimulus in the heart.

The technique for carrying out a precordial thump is as follows. The first step is to **find the midsternum**. Place the middle finger of one hand in the notch at the top of the sternum, and run the other hand along the ribs to the notch in the center of the chest (xiphoid process).



OBSTRUCTED AIRWAY: CONSCIOUS VICTIM

5 The midpoint between the notches is the midsternum. Locate this with your hand as shown.

Position your arm so that the elbow is low (just above the victim's nose) and the fist approximately 8-12 inches above the sternum.

A precordial thump that is too forceful can be dangerous so keep your elbow low and your hand 8-12 inches above the chest. This will prevent you from exercising too much force.

Deliver a sharp, quick single blow to the midsternum, hitting with the bottom, fleshy portion of the fist.

Remember that a precordial thump can be effective only if delivered within one minute after a cardiac arrest. Therefore it is a procedure used only in cases of witnessed arrest. It is a waste of precious time to do it in an unwitnessed arrest. Never do it on children or infants.

Knowing that respiratory arrest soon follows cardiac arrest, give the victim **four quick ventilations** to inflate the lungs. Follow the unwitnessed procedure) Check the carotid pulse once again for 10 seconds to assess whether or not the thump was effective in stimulating the heart. If no pulse is felt, begin one-rescuer or two-rescuer CPR.



← 1. Upper airway obstruction in a conscious victim most often occurs during or soon after eating. The victim is suddenly unable to speak or cough and may use the "distress sign" of choking by clutching his neck. He may appear dusky in color, show exaggerated effort to breathe. Prompt action is urgent, preferably while the victim is still conscious.

2. Ask the victim "**Can you speak?**" This is a way for you to identify complete airway obstruction. If the victim can speak and cough forcefully and has good air exchange, do not interfere with his efforts to expel the foreign body. In the case of a child or infant, do not place the child head down if he is able to breathe adequately in the upright position.

If, however, the victim cannot speak, has a weak cough and makes high-pitched crowing noises when trying to breathe, suspect a complete airway obstruction.

3. When the victim's airway is completely obstructed, **deliver four sharp blows** rapidly and forcefully to the spine between the shoulder blades. When giving the blows, tighten your hand to give a slight cupping effect, rather than just slapping the back. This increases the forcefulness of the blows if done correctly. Use your other arm to support the victim's chest while delivering the blows as shown.

Back blows can be administered to a victim in any position — sitting, standing or lying. Remember to hit the correct landmark (spine between shoulder blades) and to apply the blows forcefully and rapidly with a cupped hand.

4. Immediately following the back blows, administer four thrusts to the upper abdomen. The key to this maneuver is **finding the correct landmark**. Here's how: Stand behind the victim and wrap your arms around his waist. Use one hand to locate the xiphoid process and the other hand, the umbilicus.



- ← 5. Find the **point midway between the xiphoid process and the umbilicus**, and place your fist, thumb side in, on this point. This is your landmark. Although this does not sound difficult this landmark can be hard to find if the victim is bent over or if he is obese.

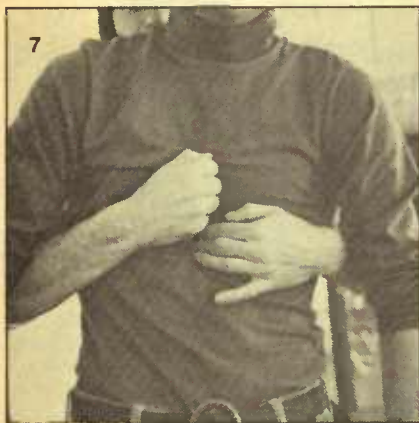
If you do not take the time to find the landmark, you will have a tendency to place your fist too high with the danger of hitting the xiphoid or of being ineffective in increasing intra-abdominal pressure. So always take the time to find the landmark correctly.



6. With the fist in position, grasp it with your other hand and press into the victim's abdomen with **four quick thrusts**. Direct the thrusts "in and up," not the other way round.

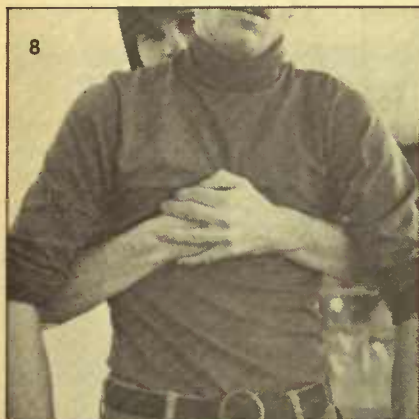
Remember that when a victim is bent over, your hand can easily slide upwards. Concentrate on keeping your fist on the correct landmark and on exerting pressure rapidly, forcefully and in an inward and then upward motion.

Once you have given the back blows and the four abdominal thrusts, look at the victim to see if he is still experiencing difficulty. If there continues to be poor air exchange, repeat back blows and manual thrusts until the airway is clear.



7. An alternate method to the abdominal thrust is the **chest thrust**. This is particularly useful if the victim is pregnant, grossly obese or in any situation where you cannot get your arms around the victim's abdomen.

Wrap your arms around the victim's lower chest. Find the xiphoid process with one hand and place your other hand on the lower sternum above the xiphoid as shown.



8. Grasp the fist with the other hand and press into the victim's chest with **four quick, backward, forceful thrusts**.

Following the backslaps and chest thrusts, assess the victim and repeat these maneuvers until the airway is clear.

There are only two alternatives for the conscious victim with an obstructed airway — either the airway will become clear or he will lapse into unconsciousness. Therefore, be persistent and perform these maneuvers as correctly and efficiently as possible.

UNCONSCIOUS VICTIM WITH AN OBSTRUCTED AIRWAY

1. When you discover an unconscious victim, establish **unresponsiveness** as in the unwitnessed cardiac arrest procedure.
2. If there is no response from the victim, **open the airway and assess for breathing**.

3. After 3-5 seconds and no sign of breathing, **attempt to oxygenate the lung** by giving four rapid ventilations. If you feel strong resistance in the victim's lungs to your breathing efforts, suspect an obstructed airway.

4. **Reposition the head** and hyperextend the neck well back to be sure that the tongue is not in the back of the throat and try ventilating again.

5. If the airway remains obstructed, reposition the head using the **jaw thrust maneuver**. With your thumbs on the victim's cheek, place your fingers under the ear lobes and use your middle and index fingers to pull up on the mandible. This maneuver displaces the jaw, pulling the tongue away from the back of the throat. If an object is lodged in the throat, this maneuver may possibly leave a space for air entry.

6. With the head in the jaw thrust position attempt to ventilate the lungs.

7. If there is still resistance to your ventilations, it is likely that a foreign body is causing the obstruction. In this case, you want to dislodge and remove the object if possible to clear the airway.

Roll the victim toward you, using your thigh for support.

8. **Deliver four sharp blows** rapidly and forcefully to the spine between the shoulder blades and remember to cup your hand.

9. After giving the blows, turn the victim supine, keeping his head turned to the side to prevent aspiration of gastric contents, mucous or clots. If you have succeeded in partially dislodging the foreign object keeping the victim's head to the side will prevent the object from falling into the back of the throat.

10. Immediately after turning the victim, give the victim **four chest thrusts**. Place one hand on either side of the victim's lower chest with the heels of the hands in line with the armpits. Wrap the fingers around the side of the victim's chest.

11. Squeeze the victim's chest four times with a quick, **downward** thrust of the arm and **inward** thrust of the hands.

12. Sweep out the mouth to remove any object that may have been dislodged. Sometimes the victim's mouth will not fall open readily and you will have to pry it open carefully with your fingers.

One of the most effective ways to open the mouth is the **cross finger technique**. Cross your thumb under your index finger, brace your thumb and finger against the upper and lower teeth, and push your fingers apart to separate the jaws.

Use your other index finger to sweep out the mouth starting from the top cheek moving it to the back of the throat and drawing out any foreign body to the lower cheek.

In any situation where you are initiating the steps of CPR and the victim has an obstructed airway you must clear the airway first before proceeding with the sequence of resuscitative maneuvers.

1. Using the head tilt method, attempt to ventilate. If you are successful in ventilating the lungs proceed with the steps of CPR. If

you are still unable to ventilate the lungs, repeat back blows, chest thrusts until you clear the airway. (Steps 7-13).



INFANT RESUSCITATION



1. If you discover an infant who appears to be unconscious, the first step is to **establish unresponsiveness**. Shake the infant's shoulders and shout "Baby, baby are you alright?" close to the infant's ear. Flick the baby's toes. If the infant is prone or side-lying, turn him onto his back. Call for help. Allow 7-15 seconds to establish unresponsiveness.

The most common error in this initial check is not taking the time to adequately establish unresponsiveness and unconsciousness. Be sure that the child is not just sleeping soundly!



2. If there is no response, tip the infant's head back to **open the airway and check for breathlessness**. Place your ear over the infant's mouth and **LOOK** at the chest, **LISTEN** for breath sounds and **FEEL** for air movement. You have 3-5 seconds to establish breathlessness.

There is a tendency to hyperextend the infant's neck. **DO NOT** do this. The airway will open adequately by tilting the head back as shown.

When assessing for breathing, take the time to do it properly and think about what you are doing. Say to yourself "Is this infant breathing?"



3. Once you have established that the infant is not breathing, cover the infant's mouth and nose with your mouth and **give four rapid puffs of air** to oxygenate the lungs. Make sure that you have a tight seal over the infant's mouth or you will lose precious air. You have 3-5 seconds for these ventilations.

Over-ventilation can be a problem. Use puffs of air only. Remember to give the four puffs in rapid succession. You are aiming for a peaking effect to completely fill the lungs.



4. If there is resistance to your ventilations, **reposition the head** to be sure that the tongue is not obstructing the airway and repeat the four rapid ventilations as in step 3.



If there is continued resistance to your ventilations, suspect a complete airway obstruction from a foreign body. Place the infant head down on your forearm while still supporting the infant's head as shown.

Deliver four sharp blows to the back in rapid succession. Tighten the hand to give a slight cupping effect and deliver the blows under the spine between the shoulder blades.



Watch the positioning of your hand and be sure that you give the blows rapidly. Remember that you are trying to dislodge the foreign body, so be forceful.



Following the back blows, sweep out the infant's mouth with a hooked finger. Insert your index finger inside the top cheek, move deeply into the back of the throat and draw out any foreign body to the lower cheek, grasp it and then remove it.

When cleaning out the mouth, be very careful not to force the object deeper into the airway. An adult finger inside a baby's mouth can make a partial obstruction complete, so be careful.



After cleaning the mouth, turn the infant over and give four rapid puffs of air as in step 3. This should take 3-5 seconds. Do this whether or not you were successful in dislodging and removing the foreign body. If airway resistance is still present and no air appears to be entering the lungs, repeat backslaps and finger probe. (Steps 5-7).

If you were successful in clearing the airway even partially, you should see the lungs rise as you give the four rapid ventilations.

Check also for gastric distension which may be reducing lung volume by elevating the diaphragm. This can occur when the airway is obstructed or when excessive pressures are used for inflation. If there is marked distension, turn the infant's head to one side to prevent aspiration of gastric contents and use one hand to exert pressure over the epigastrium between the umbilicus and rib cage.



9. After you have succeeded in oxygenating the lungs, check for a pulse. In infants, check the apical pulse (near the left nipple) as shown instead of the carotid pulse. Gently use the flat of your fingers to search for a pulse. Look for it if you don't find it immediately. You must spend 7-10 seconds establishing pulselessness. This is a long time, so count out the seconds to be sure you take this amount of time. Performing external cardiac massage on a pulsating heart can itself cause the heart to stop beating in certain cases, so be sure that there is no pulse.

10. Once pulselessness is established, start external cardiac compressions. Place the tips of your index and middle finger over the midsternum and compress the sternum 1/2 to 3/4 inches, at 80 to 100 times per minute.

Be careful not to place the fingers over the lower third of the sternum as in the case of an adult victim. The ventricles of the heart lie higher in infants and children; and due to the pliability of the child's chest, the danger of lacerating the liver is greater. When doing the compressions, look to see how deeply you are compressing the chest. Know what 1/2 to 3/4 inches looks like.

Another common error in this step is the timing of compressions. Some people have been clocked compressing the infant's chest at 200 times a minute. This is ineffective since the heart does not have time to empty completely after each compression at this rate.

11. Give the infant one ventilation on the upstroke of each fifth compression.

Cover the nose and mouth as in step 3 and give a puff of air to ventilate the infant's lungs. Count out loud:

one-two-three-four-five (puff)

one-two-three-four-five (puff) etc.

The one to five ratio of ventilations to compressions should be done smoothly with no pause or hesitation.

Giving ventilations at the wrong time can be a problem. You must ventilate on the upstroke of the compression, otherwise you are working against yourself and air cannot fully inflate the lungs.

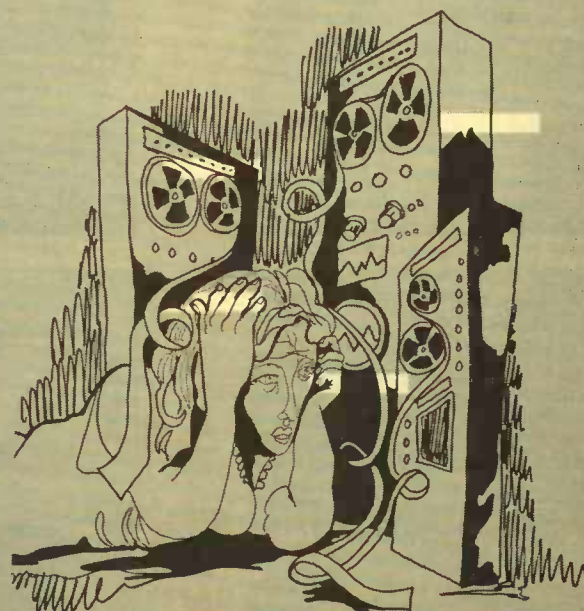
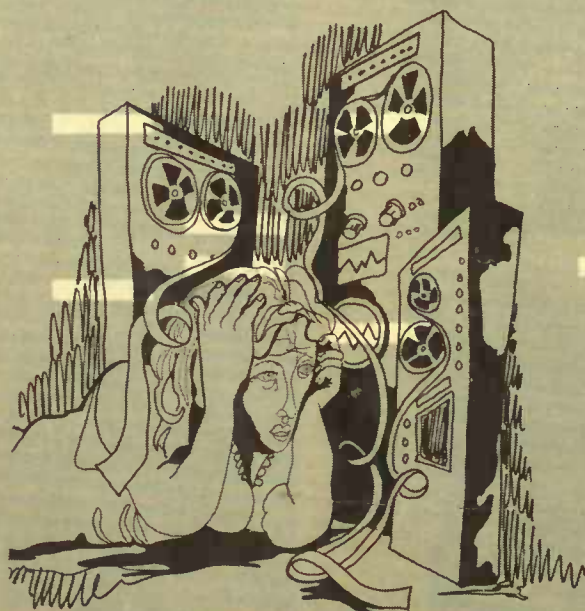
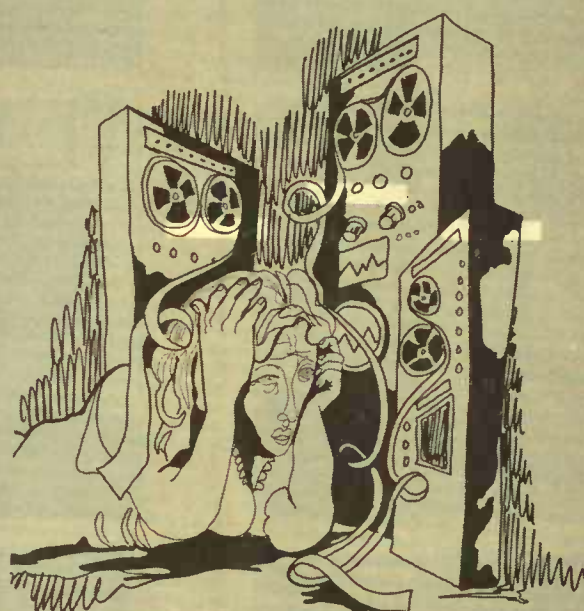
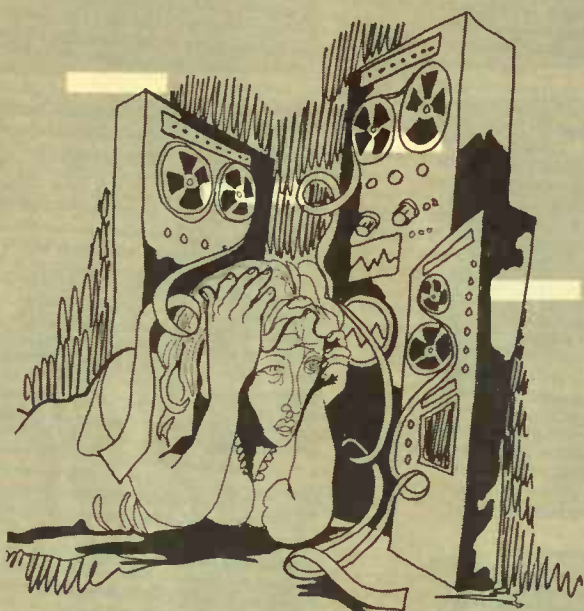
Note that your mouth should be positioned over the infant's mouth and nose at all times as in photos 10 and 11.

12. Once CPR is well underway, the infant needs to be transported to a treatment center. You can continue CPR while walking towards a car or ambulance for example.

As in photo 12, stop compressions momentarily, pick up the infant and position him on your forearm; then continue CPR and start walking. This maneuver must not take more than 5 seconds.

Patients are people too

Ruth Bolsby



It can be soul destroying to have 25 years of living erased with a ✓. A friend who had a successful kidney transplant five years ago had this devastating experience recently when she participated in a computerized medical survey.

As she told me later: "The aim of the survey quite rightly was to provide government and social agencies with information which will help them provide us with the best health care possible. "But" she continued, "the weakness in this survey like all computerized surveys is that information must be reduced to the barest facts and figures, leaving the human frustrations buried beneath a pile of data."

She explained that for the most part the computer questions were multiple choice requiring only a ✓, a "yes" or "no" or a one word answer. For example ... *When did you develop kidney disease? Were you able to continue working? What one word would describe your feelings when you had to go on dialysis?* Of the single patient it asked ... *Did you live with your family or alone? Of the married patient ... How were your relations with your spouse?*

Other questions included ... *Did you live near the hospital or out of town? How did you travel to the hospital for treatments? Did you ever require home-maker services? Were you ever admitted to a convalescent hospital? What was your greatest frustration while you were on dialysis?*

"Computer answers can be misleading because of their brevity," she laughed "when they state simply that the disease was diagnosed in 1947, the patient was treated with bed rest due to recurring infections, or when you have to explain in one sentence the mounting tensions that required psychiatric help."

"Ruth," she said "the ✓ can never convey to government authorities the frenzy of phone calls to arrange sitters or check on children home alone for lunch when a mother finds herself suddenly admitted to hospital. The frustration of trying to find transportation from outlying areas of a large city to downtown dialysis centers and clinics cannot be evaluated by a ✓," she continued. "Nor does the ✓ impart the anxiety of families of out-of-town patients flown in to large city hospitals and their search for economical accommodation while they visit the patient in the city."

Her voice rose as she asked me "how can a ✓ ever express the indefatigable human spirit which compels the single parent patient to drive himself eighty hours a week to keep a floundering business alive to provide for his three children and avoid the welfare world he fears?"

"And how" she continued "can a ✓ ever illustrate the marital tensions which relentlessly mount under the bombardment of chronic illness. You know, those tensions miraculously bring some couples closer together but they split many more of them wide apart."

By this time, my friend was becoming obviously distraught, and was waving her hands in the air to emphasize her points. "The computer," she said "does not realize that a health care team is an association of members who work together to produce results that cannot possibly be computed. I had to name the one and only one most important member of the team!"

"That meant" she went on "that I had to cross the rest of the members off the list. Who could I eliminate I asked myself — the gentle man who pads aching bones on the x-ray table, the cheerful ward secretary who brightens each day with gossip stories and jokes or the doctors who stay up nights to ensure the patients' recovery?"

"Then I thought about the nurses who dispense treatments so carefully, the laboratory technicians, the specialists who match kidney donors to recipients, the lady who, between flourishes of her dust cloth, teaches crocheting to people whose interest in life is seeping away and the sensitive chaplain who senses that a casual conversation instead of religious formality is preferred by some of his charges" she added. "I think I chose the nephrologist but I do not know why because without the rest of the team he would be unable to do his job," she concluded.

By now my friend was so agitated that she was on her second cup of coffee and well into her third oatmeal cookie. "Do you know," she asked "that I had to list three people out of all my family and friends who had meant the most to me during my illness?"

Pointing a finger at me she asked "What three people would you have chosen ... the aunt who sent a telegram saying 'we are praying for you, get well quickly', the friend who bought a wig to cover my head when I suddenly went bald; the brother who force-fed me suppers on his way home from work; the friend who removed half-baked cookies from the oven and ran to bolster sagging spirits or the ones who sent cards or telephoned each day to say 'hello'?"

"Then there were the two friends who arrived at the hospital on Easter Sunday when I was critically ill. They brought me plush bunnies because I could not eat the chocolate variety and they just wanted to wave a greeting from the hallway outside my hospital room," she elaborated. "One day my sister flew into Toronto to have lunch with me in the waiting room at the

end of the corridor. I can think of so many others. I don't know who I finally chose as the three, they all meant so much to my recovery!"

"I'll never forget the last question" she exclaimed, "I had to say in one word, imagine one, how I felt after receiving a successful kidney transplant! The interviewer must have thought I was an imbecile because I just sat there speechless while my mind raced from the distraught family of the deceased donor who had made my recovery possible, to the glories of life which had been tasteless for more than 25 years. I remembered funny things like lying in bed after the operation and watching urine collect in the catheter bag. For days my eyes never left it and I would lie breathless while the nurse measured it every hour."

"While the interviewer waited for my reply I remembered what it was like to taste food I hadn't thought of for years — silly things like dill pickles and hot dogs and a second cup of breakfast coffee. I remembered also what it felt like to have more energy; the long walks; the work on the farm; planting seeds in the spring, picking strawberries in summer and preserving vegetables in the fall. And all this I had to say in one word," she murmured. "When I finally found my voice I think I said 're-born' would do."

After listening to my friend's saga, it was clear to me that great care must be taken in reading computer survey results. Webster's New Collegiate Dictionary tells us that a computer is "an automatic electronic machine for performing calculations." In our absorption with technology we must remember the mind, spirit and emotions which make up the inner man and woman and not reduce them to a ✓. ♣

Ruth Bolsby, the author of *"Patients are people too,"* received a successful kidney transplant in August 1972 after many years of illness. She is past president of the Toronto Western Hospital Chapter of the Kidney Foundation of Canada (Ontario Branch) and is still a very active member of that organization. Her interests, in addition to writing, include sewing, crafts, reading and travel.

small mercies... big miracles

Frances Wirvin

Have you ever had a patient tell you that "waiting" for surgery is the worst time of all — not the drive to the hospital, not the pain or the first time you walk down the hall, but the "waiting"? Author Frances Wirvin, who is also a nurse, is an old hand at "waiting." In this, the first of a two-part story, she shares her worries and frustrations to offer you a little insight into what it is like to be in the patient's shoes.

In 1965 at the age of 22, I was told during a routine medical examination that I had mitral stenosis. Being relatively asymptomatic I forgot all about it once the initial surprise and worry subsided. Reminders only came when I had an annual checkup with a cardiologist.

Mitral stenosis is a common cardiac lesion. In almost all cases, rheumatic fever and rheumatic endocarditis have caused the mitral valve flaps (commissures) to thicken and to become "glued" together, thus narrowing the mitral orifice. The mitral valve is situated between the left atrium and the left ventricle. When the mitral valve narrows the left ventricle is not usually affected but the left atrium has difficulty emptying itself through the narrowed orifice into the ventricle, a difficulty that increases over time. Eventually, the heart decompensates...

Always tired

This is what happened to me in July 1976, much earlier than I had anticipated. My symptoms were acute, unexpected and frightening. They started while I was on vacation with my family in the mountains north of Montreal. To my surprise, I couldn't climb the 'wee' hill to our cabin no matter how slowly I climbed. I had shortness of breath, tachycardia and felt very tired. I slept away most of that vacation. On returning home, I was fine for a couple of days but gradually over the next two weeks the tiredness increased and I would have sudden bouts of exhaustion. Then I would just have to lie down, no matter what I was doing.

After three weeks, I felt an increasing heaviness in the left side of my chest which can only be described as a pressure feeling that radiated to the left side of my neck. I also had a very slight hemoptysis, probably due to a ruptured blood vessel in the congested pulmonary circuit.

Finally I admitted to myself that things were very wrong. But before I went to my doctor, a friend, a fellow nurse working in a cardiac unit, came to visit me. I quizzed her about cardiac surgery — the pre- and post-operative care, the difference in care between open and closed cardiac surgery, etc. I wanted to know what to expect.



I saw my cardiologist on August 16. By this time I was upset and anxious about my condition. It had advanced to the point that I couldn't lie down to sleep. Dr. P. started me on digoxin 0.25 mg daily and told me to call him after four days to let him know how I was doing. I was to see him again in a month. In the interval, it was time for me to think about an operation. He also strongly suggested that I stop smoking — a task I found surprisingly easy to do.

Two hours after taking my first dose of digoxin, I started talking about the silliest things. I also had diuresis over the next two days but by the third day could at least lie down. For days my nerves felt "jangled"; someone only needed to touch me and a sock went through me. Was this an effect from the digoxin or cigarette withdrawal? I didn't know. After four days though, I was back to 'normal' and the following week went through a barrage of tests — ECG, phonocardiogram, and cardiac fluoroscopy.

The beginning

Over a month later on September 27, my husband and I went to see a cardiac surgeon, Dr. B. After examining me, Dr. B. felt I could get away with a closed heart operation, but he would discuss it first with my cardiologist and let me know the decision within a few days. If they decided on 'closed', surgery would be done in October, if 'open heart' then, in the New Year.

My husband and I were absolutely forced — we hadn't thought that the operation would be so soon. We asked a lot of questions:

"How long would I be in hospital?"
"Ten days or so."
"When would I be back to normal?"
"Within six to eight weeks."
"How long in the recovery room?"
"Twenty-four to 48 hours."
"When would the chest tube be removed?"
"Forty-eight hours or so."

We left the doctor's office with the understanding that he would call within a few days. Imagine my surprise and the awful sinking feeling I had when he called me that same evening. He would perform a closed heart operation and I would be admitted within two to four weeks. It was all happening too fast for me. The next day I was called by his secretary and told admission would be on October 24 and the operation on the 25th.

Worries

It was at this point that I decided to start a diary. I hoped that jotting down my thoughts and feelings would be a way for me to understand and deal with all the events that were going on around me. During that time of waiting, I worried about a lot of things:

- **Pain:** This was my main worry. I am sensitive to morphine and acetaminophen (tylenol), analgesics which I knew were used after cardiac surgery.

- **Recovery period:** I just couldn't see or believe that I could be back to normal within six to eight weeks.

- **Depression:** I was already depressed by the whole situation. I knew that depression often followed serious cardiac surgery such as coronary bypass grafts. But I hadn't been able to find material on depression after mitral commissurotomy.

- **Family:** What would be the effect on my husband, two young children and other family members, all of whom had to deal with their feelings. Kevin, my seven-year-old son had just recently seen a 'nature' program about open heart surgery on television. I had a few anxious moments with him. He was worried in case they gave me "the wrong pill to sleep."

I said, "They wouldn't do that Kevin."

"Well what if they did?"

"Well mummy would ask first what it was they were giving her."

"What if it had the wrong label on the bottle?"

"That wouldn't happen Kevin." And then came his real worry.

"Are you going to die mummy?"

"No Kevin I am not." I hugged him.

Barbara Ann who is five was quite agitated, couldn't sit still and needed a great deal of gentleness at this time. Joe, my husband, said "I'd have the operation for you if I could."

But as time went by, I became more and more detached from them all. My husband knew how I felt and summed up the whole situation: "I know that very little else matters for you now, but I understand how afraid you are."

- **Sensory deprivation:** I had just read an article on post-cardiac surgery sensory deprivation. I wish I hadn't. Again though, it was mainly on more serious surgery, valve replacement etc.

- **Arrangements:** What about the practical problems? Who would look after the children? Visiting? And who would be home while I recuperated?

- **Death:** Amazingly enough, I didn't dwell too much on this, for I decided that if it was going to happen there was nothing much I could do about it.

A few days after receiving notification for admission, I had a letter from the nurse clinician in the cardiac unit, inviting my husband and I to an information class. The Tuesday before admission, off we went to the class to meet "the team" and to meet with five other patients, four of whom were having serious heart surgery. The head nurse from the recovery room conducted the class and there were talks from both the physiotherapist and social worker. The physio talked about smoking (I was glad I had stopped) and the social worker about the practical arrangements for the family and convalescence. These practical areas would be dealt with in more detail after admission. To top it off we had a talk from the head nurse about simple anatomy of the heart and about what to expect. I was told I would have a thoracotomy incision and would be awake immediately post-op. I started my count from that day on.

Saturday, the day before my admission had to be the worst day ever. I went out in the afternoon with the children and my husband Joe. In the car the children started to fight. Well that was it. I started to cry and couldn't stop. I'd only felt that bad when my parents died. I was driving the car and Joe kept asking me to pull over. But I wouldn't and kept barreling down the freeway at sixty miles an hour. The children were stunned into silence. That evening my sister arrived and I told her how awful I felt: ugly, fat (I'd gained weight since I stopped smoking), and now had a headache.

Later that evening we went to the airport to meet an aunt who was flying in to stay awhile. By this time, I was giggling hysterically. Unexpectedly, we met Dr. B. at the airport who said, "Well, you don't look like you are going for an operation on Monday." "Well, I sure feel like it," I replied. He was so concerned that I felt a whole lot better.

On my way

Sunday, I was admitted and felt panicky as soon as I reached my room. I didn't want to be there.

The nurses were very pleasant and explained everything. I had instructions from a head nurse on exercising, coughing and deep breathing. A patient profile was done. I was shave-prepped and was surprised that I felt upset about my arm being shaved. Everyone warned me that the thoracotomy incision was more painful than the sternal split. An anesthetist literally

shuffled in and shuffled out. I was definitely going home if my life was in his hands. The senior anesthetist came in a short time later, and I told him about his assistant. He stayed for forty minutes. I was so frightened of the pain but he reassured me, explaining that anileridine (leritine) and pentazocine (talwin) would do the trick. With help, I had a good night's sleep.

The next morning, I was amazed at how calm I seemed. Joe and my sister came to be with me until it was time to go to the operating room at noon. At eleven o'clock, the nurse came to give me the pre-op injection. That was when Joe became very upset. Until then, he had been terrific. So that finished me. I started to fight the sedation and did so all the way to the operating room. I remember seeing the clock in the O.R. It was twelve-fifteen ...

Drifting ... and home

Day 0. "Your operation is over." This was repeated again and again. I was annoyed at the voice and thought, "I know, I know." On another level I realized I had terrific pain yet couldn't feel it. I woke up.

The oxygen mask bothers me. It is wet. Joe is here. You shouldn't see me like this. What time is it? It is quarter to five. 'The pain is awful Joe'. I kept drifting back and forth. Seven p.m. Time is important. What is the bubbling noise? I ask Mrs. D. to call my husband. 'Tell him I'm feeling a lot better now.' 'Do you have to keep touching the chest tube. It gives me an awful thump in the chest when you do.' I wish I could wake up properly to see the monitor! Fancy that, the chest tube is disposable. Never saw one like that. Wish I could get to the other side of the bed to see!

Overnight I tried several times to void and it was very uncomfortable. I felt as if I were having retention with overflow. It seemed as if I were quite awake.

Day 1

I had an X-ray, apparently my third since coming to the recovery room. I was still there. I'm glad I didn't remember the other two! The physiotherapist gave me an IPPB* treatment and I felt as if my chest would blow up. She also had me blow into an ingenious gadget (an inspirometer) which brought red liquid from the bottom container to the top one, preferably in one expiration. When all the fluid was up in the top container, it would flow back to the bottom one, just like an hourglass. This was mine to use frequently for the rest of my stay in hospital.

Although I kept drifting back and forth, I was aware that I was being moved from the recovery room. There were six people around me to move me from one bed to another. It was done in one movement and with no effort on my part at all, really amazing. I don't remember very much else that day.

Day 2

The chest tube was removed, one point of relief. I felt kind of down because of pain. The staff was very kind while giving me gradual exercises.

Day 3 to 5

Now I was on a more active program, starting with walking as far as three doorways and back. My apex pulse was checked before and after exercise, and rest was strictly enforced afterwards. By day five I could walk the whole ward and climb two steps. In fact, I could move as much as I liked. There were other routines too: antibiotics, daily hemoglobins, blood transfusions, but at least I didn't need digoxin any more.

Day 6

Woke up feeling awful, absolutely awful. I walked along to the nurses' station-

"Do you have any pain? Can I give you something?" she asked.

"No, no pain, just a 'wee' bit of an ache up my neck and shoulder. I just feel awful." By this time Mrs. H. was quite concerned and was obviously wondering what to do. Then she said, "How about a hot pack for your neck?" That sounded just great to me, the very thing, and it was.

Day 7

I felt great, just the exact opposite to yesterday. The nurse clinician on her daily visit after the 'cardiac team' rounds suggested I be discharged the following day. She left me with the patient's discharge manual, a book with information on how to contact people in an emergency and informed me that I couldn't be left alone the first two weeks at home. She also gave me other helpful hints on various activities and symptoms.

Day 8

I was discharged, only because I had good arrangements at home. But, wouldn't you know, six days later, I was readmitted with pneumonia and left lower lobe pleural effusion. (Isn't that typical of a nurse?) I was in for ten days!

After discharge there was no stopping me. I was driving within a week, doing various household chores within two weeks. I felt fantastic and it seemed I never felt tired for now I realized how tired I'd been for several years even before the acute symptoms.

The cardiologist, Dr. P. really summed it up when I saw him early in February 1977. "Enjoying life, eh?"



Frances Wirvin, a Registered General Nurse and a Certified Nurse Midwife, received her nursing education at the Eastern District Hospital in Glasgow and the Bellshill Maternity Hospital in Lanarkshire, Scotland. Emigrating to Canada soon after the completion of her education, Frances has nursed in a wide variety of clinical settings including cardiac and thoracic surgery in Montreal. At present, she is a prenatal instructor at the Salvation Army Grace Hospital in Ottawa.

She is also the president of the Association of Professional Nurses Educated Abroad (APNEA).

Next month: Part two.

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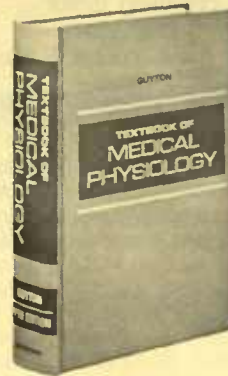
This comprehensive clinical nursing text and reference bridges the gap between theoretical knowledge of and practical skills in pediatric nursing. Completely up-dated and substantially expanded, you'll find added coverage of new equipment, inhalation therapy, dietary considerations, poisoning, drug interactions, and a whole new chapter on The Pediatric Outpatient and the Clinic Nurse.

By Gloria Leifer, RN, MA, formerly of Hunter College of CUNY. 321 pp. 184 ill. April 1977.

Hard Cover: \$9.85
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Today's most popular physiology textbook for medical students is also a superb reference for nurses. It's organized by body systems and includes relevant clinical physiology. The coverage is carefully balanced to insure that no topic is slighted or over-emphasized.

By Arthur C. Guyton, MD, Univ. of Mississippi School of Medicine. 1194 pp. 804 ill. \$27.50. Jan. 1976.

Order #4393-0.

New for 1978!

GILLIES & ALYN: Saunders Tests for Self-Evaluation of Nursing Competence, New 3rd Edition

Using clinical case studies for examples, and providing multiple choice questions for you to answer, this excellent review book examines the entire nursing curriculum. It follows the same pattern as nursing licensure exams, and serves as a perfect means for refreshing your grasp of clinical nursing matters. The book is divided into four specialty areas—Maternity and Gynecologic, Pediatric, Medical-Surgical, and Psychiatric and Mental Health Nursing. Thoroughly up-dated to reflect the most current nursing practices, this third edition has added ten new sections: amniocentesis, hyperbilirubinemia, post-partum adjustment, failure to thrive, lead poisoning, endarterectomy, laryngeal carcinoma, paraplegia, and femoropopliteal bypass graft.

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By Dee Ann Gillies, RN, BS, EdD, Divisional Nursing Director, Surgical Nursing, Cook County Hospital; and Irene Barrett Alyn, RN, MSN, PhD, Prof. of Nursing, College of Nursing, Univ. of Illinois. About 735 pp. About \$12.10. Ready March 1978.

Order #4132-6.

FALCONER et al.: The Drug, The Nurse, The Patient, New 6th Edition

You'll find more than descriptive pharmacology in this fine new 1978 edition. A new coauthor, Eleanor Sheridan, has added a wealth of clinical nursing material.

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By Mary W. Falconer, RN, MA, formerly Instructor of Pharmacology, O'Connor Hospital School of Nursing, San Jose; Eleanor Sheridan, RN, MSN, Asst. Prof., College of Nursing, Arizona State Univ.; H. Robert Patterson, PharmD, Prof. of Microbiology, San Jose State College; and Edward A. Gustafson, PharmD, Pharmacist, Valley Medical Center, San Jose. About 975 pp. Illustd. About \$19.25. Ready March 1978.

Order #3549-0.

FALCONER, et al.: Current Drug Handbook 1978-1980

Completely updated for 1978, this handy reference lists nearly 1500 drugs, their generic and major trade names, sources, dosages, major and minor uses, action and fate, toxicity, contraindications, and interactions in an easily accessible tabular format.

By Mary W. Falconer; H. Robert Patterson; Edward A. Gustafson; and Eleanor Sheridan. About 305 pp. Soft cover. About \$8.80. Ready March 1978.

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Vancouver	August 21 — 25
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Montreal (French)	August 28 — September 1
Hamilton	September 11 — 15
Ottawa	September 11 — 15
Toronto	September 18 — 22

Early application is advised. Applications will be accepted until May 15, 1978 if places are still available at that time. After acceptance, the tuition fee of \$275.00 is payable on or before July 1, 1978.

The program is sponsored by the Canadian Nurses Association and the Canadian Hospital Association and is provided in French and in English.

For additional information and application forms write to:

English Program

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Suite 800
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Faculté de Nursing
Université de Montréal
C.P. 6128
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Calendar

February

Let's Get to the Heart of the Matter

— a workshop in basic assessment skills. To be held on Feb. 20-21, 1978 in Vancouver, B.C. Fee: \$50. Contact: *Division of Continuing Nursing Education, 1st Floor, Instructional Resources Centre, University of British Columbia, Vancouver, B.C. V6T 1W5.*

Nursing and Politicking.

A one-day seminar to be held at the University of Toronto on Feb. 25, 1978. Keynote speaker: Laura Barr. Contact: *Darlene Berry, 110 Cambridge Ave., Toronto, Ontario, (416) 463-6620.*

Quality of Life A one-day seminar

to assist participants to reach a better understanding of the individual undergoing ostomy surgery and rehabilitation. To be held on March 17, 1978 at the St. Boniface General Hospital, Winnipeg, Man. Contact: *Enterostomal Therapy Department, St. Boniface General Hospital, 40 Tache Avenue, Winnipeg, Man., R2H 2A6.*

25th Annual Congress of the American Operating Room Nurse Association

to be held on March 12-17, 1978 in New Orleans, Louisiana. Contact: *The Association of Operating Room Nurses, 1017 East Mississippi Ave., Denver, Colorado, 80231.*

March

Neonatal Intensive Care Course

sponsored by the Registered Nurses Association of Nova Scotia to be held on March 26, 1978 at the Grace Maternity Hospital in Halifax, N.S. Contact: *Director of Nursing Education, Grace Maternity Hospital, 5821 University Ave., Halifax, N.S. B3H 1W3.*

Continuing Nursing Education at the University of Alberta, 1978:

Ethics and nursing — March 10. Fee: \$15;
Management skills for nurses: an approach to problem solving — March 16-17. Fee: \$20;
Budgeting for nurses: planning, preparation, utilization — March 20, Fee: \$20;
Current concepts of care for the ostomy patient — March 31. Fee: \$15;

Simulations and learning games in nursing education — April 6-7. Fee: \$35;

Advanced obstetrics refresher course — April 24-28. Fee: \$60;
The high risk newborn: identification and stabilization — May 10-12. Fee: \$45;

Nursing — Pharmacy workshop — May 26;
ECG Interpretation — June 26-29. Fee: \$75.

Contact: *Faculty of Extension, The University of Alberta, 82 Ave. and 112 St., Edmonton, Alta., T6G 2G4.*

April

Gynecologic Oncology Nursing Seminar

to be held March 16-17, 1978 at the Johns Hopkins Hospital Baltimore, Maryland. Fee: \$75. Contact: *Program Coordinator, Office of Continuing Education, Turner Auditorium, 720 Rutland Ave., Room 22, Baltimore, Maryland, 21205.*

Orthopedic Nursing Workshop

to be held on April 13-14, 1978 in Saskatoon, Saskatchewan. Fee: \$30. Resource person: Clara A. Donahoe R.N., executive director of the Orthopedic Nurses Association, Atlanta, Georgia. Contact: *Norma Fulton, Associate Professor and Director, Continuing Nursing Education, College of Nursing, University of Saskatchewan, Saskatoon, Saskatchewan, S7N 0W0.*

Sixth Annual Intensive Care Symposium

to be held on April 14-17, 1978 at the Americana Hotel, Bal Harbour (Miami Beach), Florida. Sponsored by the Department of Surgery, Surgical Intensive Care, University of Miami School of Medicine. A.M.A. accredited. Contact: *Division of Continuing Medical Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami, Florida 33152.*

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Books

Fluids and electrolytes: a practical approach 2d ed. by Violet R. Stroot, Carla A. Lee and Ann C. Schaper. Philadelphia, F.A. Davis Company, 1977.

Approximate price \$9.40

Reviewed by Agnes T.H. Choi-Lao, Assistant Professor, 2nd year medical-surgical nursing coordinator, school of nursing, Ottawa University, Ottawa, Ontario.

The philosophy of this book can be expressed in two words: "pragmatic" and "simplified." The authors have directed this book primarily to the nurse as a continuing student and as a practitioner.

The text has six sections. Section I provides the fundamental concepts and basic terminology in fluids and electrolytes. Sections II to IV discuss body fluids, electrolytes, and acid-base balance. The emphasis of these sections are (i) on recognizing various kinds of fluid and electrolyte imbalances, and (ii) on taking the necessary steps in the correction of these impending problems. The material is arranged logically and includes information about causative factors, signs and symptoms, laboratory tests, treatments and nursing responsibilities.

Section V is entitled "Clinical Situations." Various disease processes are presented to discuss how they affect fluid and electrolyte homeostasis.

As the book is not intended to be a comprehensive textbook, it lacks depth in theory. However, the text is designed to deal more with practical application of principles of fluids and electrolytes, and it is successful in this respect. Examples of the inclusions are respiratory diseases, acute and chronic renal failure, adrenal disorders, congestive heart failure, shock and burns. In each clinical situation, physiology is reviewed. The deviations in fluid, electrolyte and acid-base balance are identified, and the management of these problems are followed.

Section VI focuses on nursing techniques. These techniques are systems which provide means to alternate fluid, electrolyte, and acid-base levels in the body, for example: peritoneal and hemodialyses, gastrointestinal intubation and tube feeding, venipuncture, intravenous therapy, and tracheotomy. In each case, principles, procedures and nursing responsibilities are discussed in detail.

General organization of subject matter is very good especially with the use of sub-headings in the extra-wide margins. One of the outstanding features of the text is the use of case studies and quizzes at the end of some chapters. These case studies help to encourage application of theory to clinical situations, and the quizzes assist the learner in evaluating his knowledge. Answers to case studies and quizzes are given in the appendices. A glossary is also provided at the end of the text to aid the reader in acquiring a working knowledge of terminology. Furthermore, there is a thorough bibliography at the end of each chapter for the reader's use.

Patient Assessment and Management by the Nurse Practitioner by Dee Ann Gillies and Irene B. Alyn, 236 pages. Philadelphia, W.B. Saunders Company, 1976.

Reviewed by Sandra Klyne, Clinical Co-ordinator, Ambulatory Services, Jewish General Hospital, Montreal, Quebec.

Rarely do authors unnecessarily limit the scope of their readership. Dee Ann Gillies and Irene Alyn do so in both title and preface, and in fact do injustice to their own useful and most readable little book.

The title tends to convey that the information contained in the book is solely of interest to nurse practitioners or those intending to become nurse practitioners. To be sure, some of the text — for example the excellent and generously illustrated chapter on the physical examination — is directed to this group. However, there are comprehensive chapters as well on interviewing technique, laboratory tests and special examinations, and psychosocial assessment and intervention, which are among those aspects of the book concerning all of us in clinical practice. Together they comprise a handy refresher and reference for the seasoned health worker, and a host of ideas for an advanced student perfecting his or her skills.

The preface may also be expressing unnecessary limitation. It states: "Nurse practitioners are particularly well suited to act as primary care givers to chronically ill patients as a result of certain skills and habits they bring from their nursing education and experience." While one cannot dispute the truth of this statement, it must be noted that nurse practitioners are successfully functioning in emergency rooms, outposts, pediatric practice, and other areas where the most acute problems may arise. Granted that no one text can

prepare a nurse to deal with all possible contingencies, the same kinds of skills that the book imparts are useful in all such settings.

The book is well-organized, dealing with general skills of interviewing, assessment, and planning in the first six chapters, and with management of specific problems in the latter six. Among these specific problems are hypertension, diabetes mellitus, obesity, and alcoholism. Each problem is defined in terms of its pathophysiology, signs, symptoms, and methods of diagnosis and treatment.

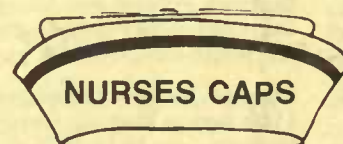
There is also, at the end of the book, a listing of normal laboratory values for quick reference.

No single volume will make a nurse practitioner of anyone. But this one is a good place to begin. It is concise, clearly written, and useful to any actively practicing nurse.

Health happenings ...

Testimony during a recent \$1.5 million malpractice suit against a Toronto doctor and hospital indicated that it was a nurse who detected symptoms of diabetes in a sick youth after three M.D.'s had failed to spot the disease. The young man had been examined by a general practitioner, a neurologist and an internal specialist who is also an endocrinologist before the nurse noticed that the patient's breath had a "fruity odor." Subsequent tests proved that he did, in fact, suffer from diabetes. The patient's family alleges that the care provided at the hospital was inadequate and that, as a result, the young man when into a diabetic coma, suffered a cardiac arrest and brain damage.

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Books and documents

1. Alcoholism: development, consequences, and interventions. Edited by Nada J. Estes and M. Eth Heinemann. Saint Louis, Mosby, 1977. 332p.
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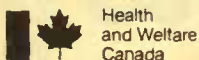


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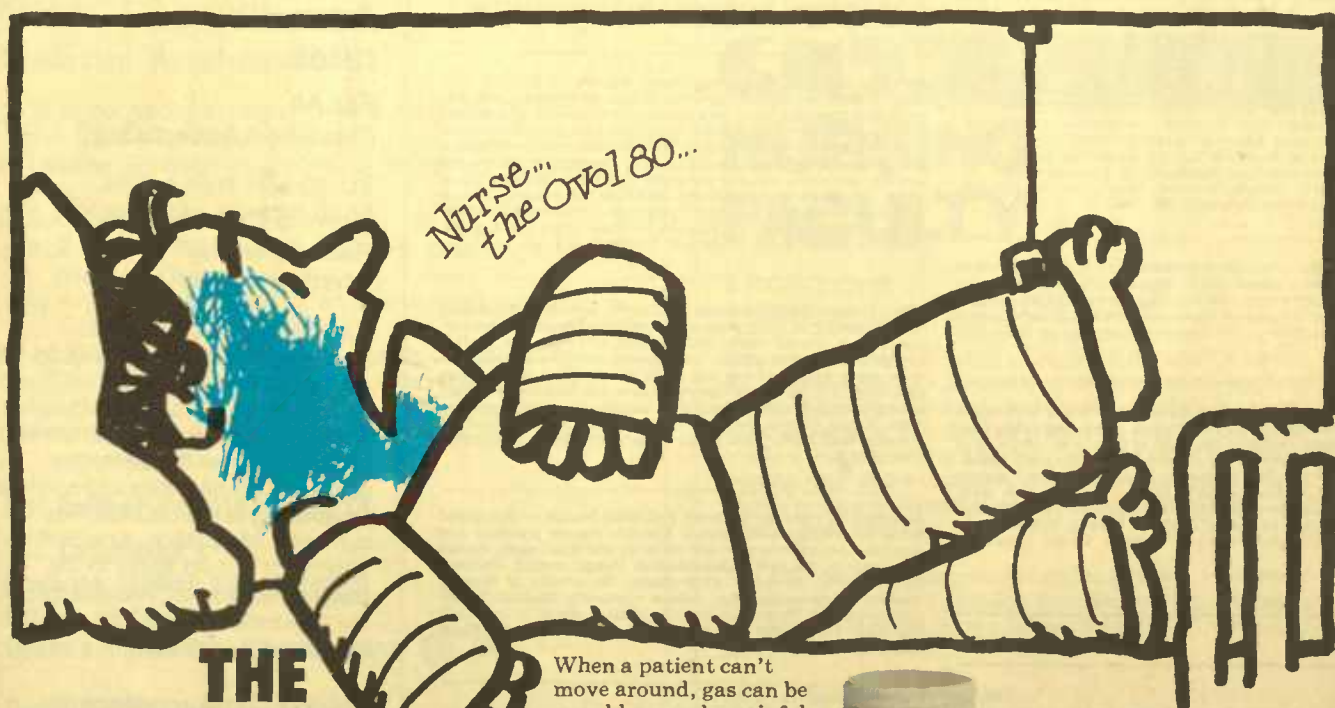
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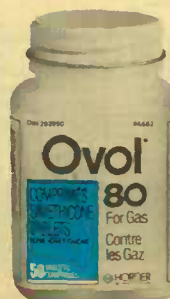
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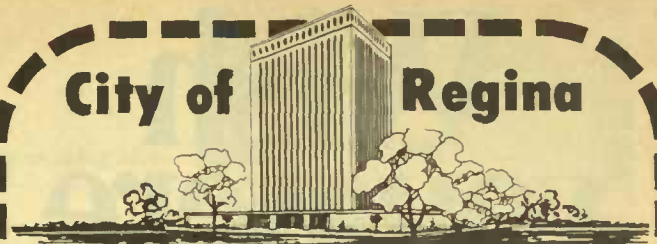
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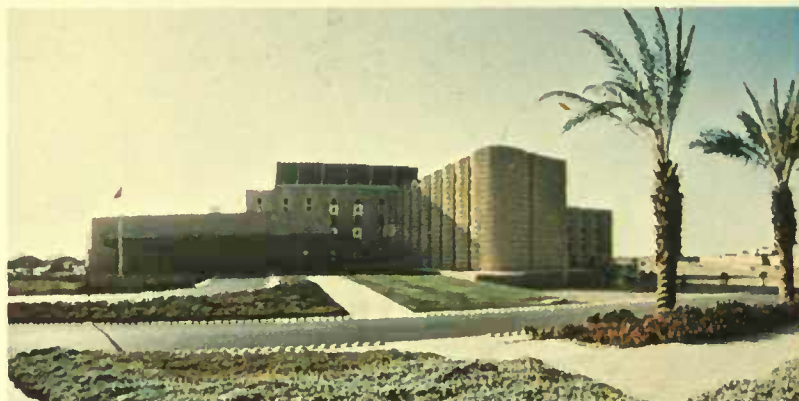
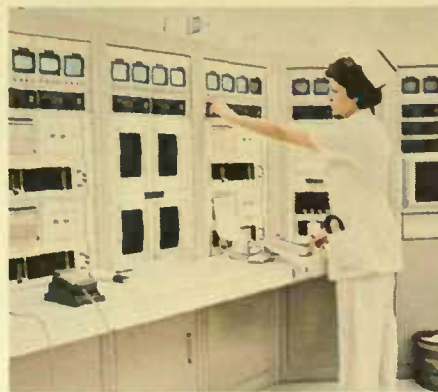
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For brief prescribing information, see page 11

Nurse

Aug 7 1978

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The Canadian Nurse

March 1978

The official journal of the Canadian Nurses Association published monthly in French and English editions.

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Remember last March when our cover featured a color photo of the 16 nursing school pins that over the years had been donated to the CNA Archives collection? We asked you then to help make the collection more representative by sending along your own contribution. As you can see from this month's cover, this appeal was successful. Today there are more than 45 pins on display at CNA House and room for still more. If you would like to see your school of nursing represented, you should contact the librarian, CNA House. For identification of the pins, see page 3 of this issue. Photo by Studio Impact.

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses Association.

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Perspective

In 1971, Canada became what demographers call an "aging society." That year, eight of every 100 people living in this country had reached or passed their 65th birthday. By the turn of the century, Statistics Canada estimates that this number will have grown to 12 in every 100. And 50 years from now, when the legendary boom babies are transformed into senior citizens, an astonishing one in five (20 percent) of Canadians will be 65 or older. The implications are mind-boggling. They touch almost every aspect of living that you can think of: pensions, housing, transportation, employment, leisure and community services. But most of all, these numbers have a direct bearing on the kind of health care planning that we should be doing now.

The Science Council of Canada estimates that three-quarters of today's over-65 population are afflicted with some form of chronic illness. Although this group makes up only eight percent of the total population, they account for more than one-third of all hospital days.

How are we going to meet this challenge? Obviously, even a dramatic increase in hospital beds is not the answer. As the Science Council warns: "A continued increase in the demand for medical facilities will occur in the years ahead. Careful planning is needed to prevent costs escalating to unsupportable levels. In the process we will need to re-examine our priorities, and to question the relative value of different modes of medical care, both in institutions and in the home."

Yes, we will need more hospital beds. Yes, we will need more staff nurses and other health professionals trained to meet the special needs of the elderly. But, most of all, what we will need is a more accommodating and accepting attitude towards the aging process and those who are no longer young. Nurses (and society generally) are



going to have to adopt a more flexible and, at the same time, more positive approach towards our aging population. We need to make it possible for people over 65 to remain in their homes, in the community and in the workplace for as long as they can.

We need visiting nurses who recognize that a person does not stop being a useful member of society on the day he has his 65th birthday. We need nurses who start early to teach the kind of preventive health care that keeps people fit and free from chronic illness. We need nurses who are willing to spend the extra time it takes to be sure that an older person with a chronic illness really understands how to manage his medication on his own at home.

And, yes, inevitably we will need more institutional care for those who can no longer profit from remaining in the community. But let it be the kind of care that, like The Priory Method, follows the golden rule. After all, some of us will be on the receiving end of that care and sooner than we may think.

— M.A.H.

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Herein

In this issue, a look at "The Greying of Canada." Right now there are more than two million people in this country who have passed their 65th birthday. What are we doing to meet their special health care needs? How can nurses, doctors and administrators work together to develop a system that will make these years challenging and creative, a system that fosters self-respect and continued growth? For some of the answers, read Vera McIver's description of how the "Priority Method" is working in Victoria, B.C. Beginning on page 19. In the same vein, "One Day the Door Closes" and "Communicating with the Hard-of-Hearing," provide more food for thought on the subject of aging.

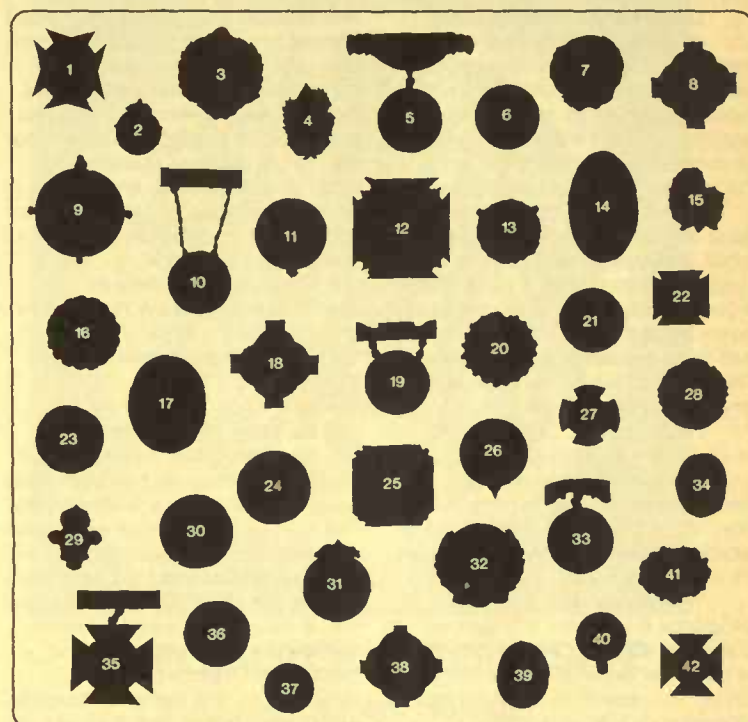
Annual meetings are coming up, a time for elected officials to account to membership for their actions in the past year and receive direction for the months ahead. A perennial question at these gatherings concerns the subject of membership fees. In this issue, CNA's director of administrative services, Beryl Darling, explains how your provincial membership fees help to support our national association and what this money entitles you to in terms of member services. "This is YOUR Association" begins on page 14, followed by a three-page summary of CNA's financial statement for 1977.

Also in this issue, meet columnist Corinne Sklar, a nurse whose interest in medical jurisprudence enticed her to return to school to study law. Her column, "You and the law," will be a regular feature of future issues of *The Canadian Nurse* and *L'infirmière canadienne*. The first one appears on page 10 of this issue.

Six years ago, the **Boudreau Committee** recommended to the federal Minister of Health and Welfare that the development of the nurse practitioner category (of nurses) be regarded as the highest priority in meeting the health care needs of Canadians. What has happened since then? What exactly is a nurse practitioner? How does a person go about becoming a nurse practitioner in Canada today? **Next month**, CNJ tries to answer some of these questions in a special three-part feature on the nurse in the expanded role.

Key to cover photo:

1. St. Eugène Hospital, Cranbrook, B.C. (1923)
2. Payzant Memorial Hospital, Windsor, N.S. (1935)
3. Toronto General Hospital, Toronto, Ont.
4. Hôtel-Dieu de Chicoutimi, Chicoutimi, Qué. (1951)
5. Montreal General Hospital, Montreal, Qué.
6. Calgary General Hospital, Calgary, Alta. (1943)
7. St. Elizabeth's Hospital, Sudbury, Ont.
8. Royal Victoria Hospital, Montréal, Qué.
9. Hôpital de Sherbrooke, Sherbrooke, Qué.
10. Saint John General Hospital, Saint John, N.B.
11. Victoria Public Hospital, Victoria, B.C.
12. John H. Stratford Hospital, Brantford, Ont. (1889)
13. Brantford General Hospital, Brantford, Ont. (1921)
14. Vernon Jubilee Hospital, Vernon, B.C. (1914)
15. Hôpital du St-Sacrement, Québec, Qué. (1951)
16. Memorial University, St. John's, Nfld.
17. Metropolitan General Hospital, Windsor, Ont.
18. Lady Stanley Institute, Ottawa, Ont. (1920)
19. Vancouver General Hospital, Vancouver, B.C.
20. Toronto Western Hospital, Toronto, Ont.
21. Calgary General Hospital, Calgary, Alta. (1949)



22. Royal Jubilee Hospital, Victoria, B.C.
23. Women's College Hospital, Toronto, Ont.
24. Metropolitan Demonstration School of Nursing, Windsor, Ont.
25. Hamilton City Hospital, Hamilton, Ont. (1921)
26. St. Luke's General Hospital, Ottawa, Ont.
27. Toronto East General Hospital, Toronto, Ont. (1942)
28. Kelsey Institute, Saskatoon, Sask.
29. Hôtel-Dieu de Québec, Québec, Qué. (1948)
30. Victoria Hospital, Winnipeg, Man.
31. Misericordia Hospital, Winnipeg, Man. (1933)
32. Ottawa General Hospital, Ottawa, Ont. (1913)
33. Winnipeg General Hospital, Winnipeg, Man. (1931)
34. Jewish General Hospital, Montréal, Qué.
35. Royal Inland Hospital, Kamloops, B.C. (1930)
36. Regina General Hospital, Regina, Sask. (1919)
37. General Hospital, Glace Bay, N.S. (1961)

38. Moose Jaw Union Hospital, Moose Jaw, Sask. (1959)
39. St. Paul's Hospital, Vancouver, B.C. (1928)
40. Moncton Hospital, Moncton, N.B.
41. Algonquin College, Ottawa, Ont.
42. Regina General Hospital, Regina, Sask.

Did you know ...

that CNA members have the option of receiving their professional journal in either of Canada's official languages? Any member now receiving the journal in either English or French and wishing to make that change, should write to the Circulation Department, Canadian Nurses Association, 50 The Driveway, Ottawa, Ontario, K2P 1E2, indicating their wish to receive either *The Canadian Nurse* or *L'infirmière canadienne*. Non-members who would like to receive either journal on a regular basis should write to the same address, enclosing a cheque for \$8.00 (Canadian) for one year or \$15.00 for two years. (Outside Canada: \$9.00 for one year; \$17.00 for two years).

The Canadian Nurse invites your letters. All correspondence is subject to editing and must be signed, although the author's name may be withheld on request.

Input

Qualifications for re-entry

It is with some concern that I am learning of proposed changes regarding nursing competency. Of specific interest to me is the suggestion that I will have to work for a specified period of time in order to be eligible for certificate renewal.

I have just left the work force to give my full attention to raising my child. I deeply resent anyone suggesting that being a good mother now will in any way affect my ability to be a good nurse later. Surely I am not to be penalized for remaining in the home during the first few years of my son's development.

I have always considered myself a good nurse. Throughout my nursing career I was always self-motivated to improve my nursing and leadership skills. I would like to continue to keep abreast of changes in our profession.

Where do I find inservice programs if I am not affiliated with a particular hospital? Who will decide if a particular experience or seminar is to be considered a credit to my competency? Who is going to finance a supposed ongoing educational program for nurses who are temporarily out of the work field? Where can such programs be found?

If hospitals are finding that nursing personnel returning to the work force are not performing as well as could be desired I suggest that they have only themselves to blame. This would indicate to me that their evaluations and inservice programs are failing.

There appears to be a serious lack of discussion of this matter in your magazine. The proposed changes will have a serious effect in the nursing community. You owe it to your readers to let them know about this.

— Janice James, Owen Sound, Ontario.

less than 50 days in one year within the last five years" to take a "re-entry program" before receiving certification. It is the view of the College that "a member who has been out of practice for more than five years requires updating to function competently on re-entry to practice." At present the Certificate is renewed annually on payment of fee, without condition.

The proposed date for implementation of new requirements is 1st January, 1980.

Your comments are invited.

Nursing conundrum

I am delighted that Mohamed Rajabally's article in the September issue evoked such a lively debate. The nursing intelligentsia have been debasing the profession far too long with neologistic tripe. I suppose it is a sign of the times that some nurses feel a desperate need to explain themselves. Conceptualizations, models and theories abound, ostensibly in the name of scientific explanation but in fact they are all symptoms of professional insecurity. Happy indeed are the nurses who can still feel comfortable caring for people surrounded by all the bombast and clutterances of their anxious colleagues.

The fundamental reason for all this gibberish is quite simple but too hard for some people to accept, there is no such thing as nursing. Show me a universally accepted or acceptable definition of the term "nursing." Ask yourself why you can't.

Surely if one cannot even define a problem it is sheer folly to try to solve it. All one succeeds in doing is complicating it and that is precisely what we have done.

Certainly, some things can and should be said about nursing; it is a bastard science at best which, hopefully, has not entirely shed its artistic precursor. It could be described as an art of caring, with scientific and technological trappings. Its uniqueness stems purely from its defiance of rational and acceptable definition, certainly not from any imaginary discrete body of knowledge. It is as holistic as a magpie's nest.

Such expressions as "patient-centered care" and "individualized care" are redundant and misleading as are most nursing care plans, particularly the standard kinds; we are not caring for pigeons. Nursing diagnoses, nursing histories and many aspects of team nursing are carried out at the expense of nursing care time and are designed to make the profession, rather than the patient, feel comfortable. Theories aimed at satisfying patients' needs are unworkable if they ignore the needs of the nurse; conceptual models built thereon serve only to irritate.

Much if not most nursing research is ill-directed, valueless and deservedly collects dust. The credibility gap between nursing education and nursing practice is truly incredible — small wonder that nurses and doctors still prefer to play games.

— David J. Davis, R.N. R.P.N., Burnaby, B.C.

Reasoned dispute

I am a strong believer that one should be as generous, if not more so, with praise as with criticism. I therefore, wish to express my appreciation for the December issue of *The Canadian Nurse*. As one of those who wrote to take exception to "The Tower of Babel" I was pleased to see the coverage given both sides of the controversy Mr. Rajabally stirred up. I was particularly impressed with the comments made by Gail Prowse and Evelyn T. Adam.

Although I disagreed with much of the content and form of this article, the author is owed thanks for stimulating the responses, both pro and con, to his article.

I am sure it is as heartening and stimulating to others, as it is to me, to know we have so many bright and articulate colleagues across the country. Engagement in reasoned disputation, of the type displayed in the December issue on this topic, can only help to unite and enhance the profession.

Thank you for providing the forum for this discussion.

— Dawn E. McDonald, Reg. N., M.Sc.N., Sessional Lecturer, University of Victoria, Victoria, B.C.

A healthy decision

Some time ago, a reader in Etobicoke, wrote to you about the difficulties involved in banning the sale of cigarettes in a hospital Tuck Shop. I am writing to assure him that it can be done.

A few years ago, volunteers who run the shop in our hospital decided to support administration's crackdown on smoking by stopping sale of cigarettes.

No statistics have been compiled, but even if this move doesn't stop people from smoking, at least it has raised everyone's consciousness. This is the place to begin because smoking is not an acceptable, normal social habit, and it is sadly detrimental to health.

The shop has been losing money because of this decision, but it has brought a number of people on the better side of health.

— Nicole P. Legaré, Coordinator, Nursing Education and Research, Ottawa General Hospital, Ottawa, Ontario.

Issues in Canadian Nursing

(See "Books", page 54)

... It is indeed encouraging to have another publication by Canadian nurses, a further contribution to a somewhat limited nursing repertory. (Issues in Canadian Nursing, by Betsy LaSalle and M. Ruth Elliot, Prentice-Hall Canada Ltd., 1977). The issues are by no means exclusively Canadian but the views and attitudes expressed reflect a Canadian perspective.

It is quite possible that student in undergraduate and graduate programs may be among the first to become acquainted with this new publication, but what of the much larger group of practitioners across Canada? It is vitally important that they too become apprised of the thinking of some of our outstanding Canadian nurses on the critical issues as set forth in this book.

— Ruth E. McClure, Former Dean, University of Alberta, Edmonton, Alberta, Professor Emeritus, University of Alberta, Victoria, B.C.

Editor's note: In October 1977, the College of Nurses of Ontario presented a proposal to Ontario nurses concerning future requirements for issuance of a Certificate of Competence to an RN or RNA. The proposed policy change would make it mandatory for those "not employed in nursing for

Right to practice

Enclosed you will find a newspaper article concerning the fight of the English-speaking nurses "La Belle Province." I am forwarding this information to fill you in on what is actually taking place here. After reading the story, perhaps you could write an article in *The Canadian Nurse* so the rest of the provinces are aware of the situation that now exists here.

These girls have had no support or encouragement from anyone but their families. I think it's about time more people learned about the raw deal that awaits them after three years of training.

We accept the fact that they must speak French to stay here to work, but **WHY** are they not granted their licence, after they've passed their RN exams so they may go elsewhere?

Anything you can do to help them in their fight for their *right* to work in their chosen profession, would be most appreciated.

J. Hill, Roxboro, Quebec.

Editor's note: The writer refers to the employment problems encountered by English-speaking graduates of nursing programs in the province of Québec who, under the terms of that province's Official Language Act, (July, 1976) must pass a French-language fluency test before obtaining their permanent licence. Graduates who have passed their RN's may obtain a one-year work permit. Those who do not meet the language proficiency tests administered by the province before the end of that 12-month period, can no longer practice in Québec. The fact that these nurses are not registered in their own province effectively prevents them from working in other Canadian provinces since provincial law requires a nurse seeking registration in another province to offer proof of registration/licensure in the province in which she obtained her nursing education. Saskatchewan, which does recognize temporary permits, will only consider reciprocal registration if the nurse who applies is residing in that province and has proof of employment.

Licensure/registration

procedures are spelled out in the Nurses Acts of the various provinces and are the legal responsibility of provincial nurses' associations in all provinces except Ontario where the College of Nurses assumes this responsibility.

Call for better anesthetic devices

A coroner's jury examining the death last Fall of an Ottawa woman has determined that a defective anesthetic gas valve caused the death (Ottawa Citizen, Thursday, January 19, 1978). The jury called for improvements in the design and operation of hospital anesthetic machines.

Incidents of death also occurred in Sudbury in 1976 when patients received wrong ratio of anesthetic gases due to erroneous hook-up of outlet tubings.

How can incidents like these be prevented in the future? One suggestion is to introduce an on-stream gas analyzer, using gas chromatography or mass spectrometry, between the anesthetic machine and the patient to verify the composition of the gas administered.

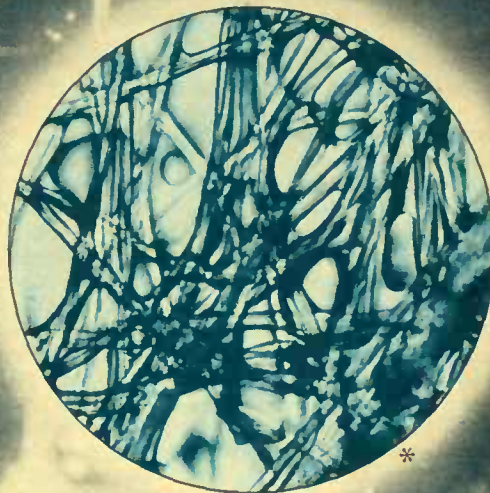
Such a gas analyzer would be independent of the manufacturer's flow-control systems and would provide independent and graphic readings of the monitored gas-mixture being given to the patient.

— Agnes T.H. Choi-Lao, Assistant Professor, School of Nursing, University of Ottawa, Ottawa, Ontario.

Did you know ...

The Winnipeg Health Sciences Centre has been provided with an Apollo Radiant Warmer for the treatment of burns. The warmer is a protective shield which keeps the temperature constant over and around the patient's burned tissue area. It warms the surrounding air as well as the burn site, a necessity since burn patients suffer from severe chills.

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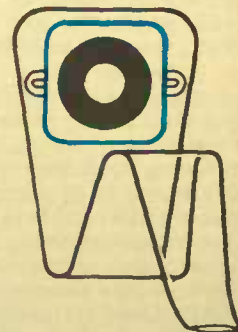
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News

ICN urges nurses to accept responsibility for better conditions

"Nurses must speak for nurses; it is essential for national nurses' associations to have responsibility for the social and economic welfare of nurses," according to the president of the International Council of Nurses, Olive Anstey. She made the statement following an announcement at ICN headquarters in Geneva that the theme for International Nurses Day 1978 would be "Better Conditions for Nurses — Key to Better Health Care."

International Nurses Day is observed in many countries on May 12, anniversary of the birth of Florence Nightingale. In other countries the date chosen corresponds to a significant event in nursing in that country.

"Nurses must be prepared to control their own conditions of work and life, whether they do this through the professional organization or, as is the case in some countries, as an independent component of a broader organization."

"When nurses defend their own interests, patients also gain," she said. "Conditions for nurses are closely linked to nursing practice. The practice of nursing is influenced by the climate in which nurses work — their status, how the public and other health professionals view them, how nurse experts can be kept in nursing."

Anstey expressed optimism about the achievement of economic justice and due recognition for nurses. "The adoption by the International Labour Organization in 1977 of a Convention and Recommendations on the conditions of work and life of nursing personnel confirms that some of the issues crucial to nursing have been identified. ICN and its 88 member associations are working to have this international instrument ratified by national governments so that nurses — and therefore their patients — in each country will reap the benefits in terms of conditions conducive to the provision of quality nursing practice."

RNAO considers competency tests

The president of the Registered Nurses Association of Ontario has supported the right of that province's licensing body, The College of Nurses of Ontario, to regulate the practice of nursing in order to protect the public. Following a meeting of the RNAO Board of Directors, president Irmajean Bajnok reported: "The board unanimously supports the profession's right to self-regulation through the College of Nurses of Ontario and believes that, to relinquish any aspect of the right to self-regulation means relinquishing our separate identity as a profession."

Draft policies affecting certificates of competence issued by the College of Nurses of Ontario have been the subject of widespread controversy since they were made public late last Fall.

"We are encouraged to see so many nurses across this province involved in the issue," Bajnok said. "However, the proposals are just that — proposals — and the College has requested reactions and recommendations."

Included in the proposals is the recommendation that in order to qualify for a certificate of competence a registered nurse must have been employed in nursing for 50 days in one year within the last five. Those who do not qualify will be required to complete a re-entry program. Currently certificates are issued annually upon request.

"We believe that the intent of the College's competency proposals is positive. All registered nurses have a responsibility to ensure that the public receives competent care. It must be realized that, with modern techniques and technology, knowledge and skills become obsolete very quickly. Nurses who have not practised recently are unlikely to be familiar with current nursing knowledge and practices," she said.

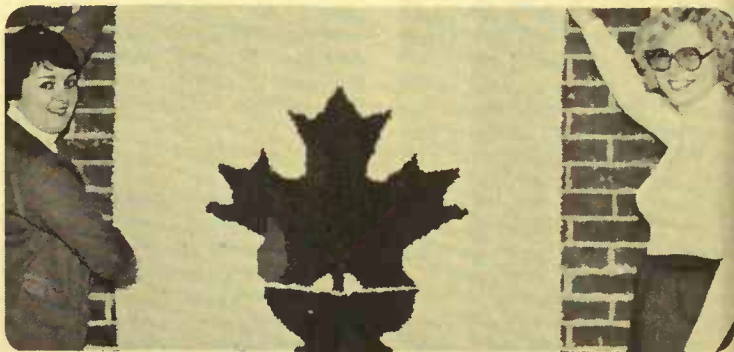
RNAO chapters across the province are holding meetings to discuss the proposals and their impact on the profession. Recommendations from these meetings will be presented to, and discussed with, the College.



Members of the Canadian Nurses Association Testing Service Blueprint Committee for the R.N. comprehensive examination are pictured during a recent meeting at CNA House in Ottawa. The eight committee members, appointed by the Committee on Testing Service, were selected to provide regional representation and equal representation for English and French-speaking members.

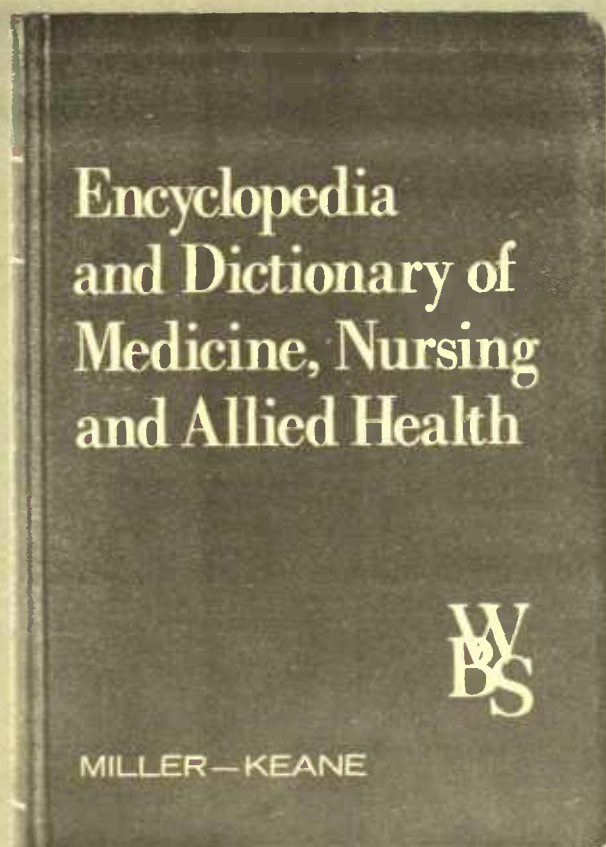
The committee begins a new cycle of test development activities — the definition of major nursing areas that can be tested on a registration exam and the sampling of content to provide a framework for the development of a future exam. This exam will be based on the blueprint published by the CNATS in 1977.

Committee members are: (left to right) **Jean Magee**, director, school of nursing, Victoria General Hospital, Halifax; **Margaret Nugent**, director, nursing of adults, Health Sciences Centre, Winnipeg; **Lee Cadman**, assistant director, University of Alberta Hospital, school of nursing, Edmonton; **Huberte Poirier**, assistant professor, school of nursing, Université de Moncton, Moncton, N.B.; (second row) **Lise Riopelle**, consultant in basic nursing education, ONQ; **Margot Phaneuf**, (co-chairman), professor, College Saint-Jean-sur-Richelieu, St. Jean, Quebec; **Charmaine Sayer**, (co-chairman), medical coordinator, Women's College Hospital, Toronto; **Kathleen Webb**, director of nursing, North Bay Civic Hospital, North Bay.



The main foyer of CNA House is brighter these days with the addition of a new hooked rug. The work of two CNA staff members, the rug depicts the Canadian Nurses Association traditional symbol — the Leaf and the Lamp. The idea was the brainchild of Danielle Reinhardt (left), the receptionist at CNA and Brenda Kropp, junior secretary for the executive director. Brenda drew the symbol onto the canvas backing, while Danielle hooked the rug in less than a month as a voluntary Christmas project for CNA. The staff of CNA House thank them both for their fine work. (Photo by Studio Impact)

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News

Energy costs for stairclimbing and sexual activity reevaluated

Since 1969, when a now-classic study of sexual activities in the post-coronary patient was published, the ability to climb two flights of stairs has been equated with readiness to resume sexual activity after a heart attack. A recent study by a faculty member of the University of Rochester School of Nursing, however, concludes that this advice should be given cautiously, since sexual activity may actually prove more strenuous.

Sue Elster, R.N., M.N., instructor in nursing at the school of nursing and clinician at the University's Strong Memorial Hospital, presented her findings recently at the American Heart Association Scientific Session in Miami, Fla. Her research reevaluated the 1969 study, one part of which involved a group of middle-aged post-heart attack subjects whose heartbeats had been recorded by portable heart monitors during sexual activity. Their heart rates had also been recorded for such routine work activities of daily living as walking, stairclimbing, doing routine paper work, and developing pictures in a darkroom. When the average maximal heartbeats per minute for work activities were compared with the beats per minute during sexual activity, the rate was higher for work activities.

"Since then," says Elster, "the literature concludes that one could resume sexual intercourse after sustaining a heart attack if one could climb two flights of stairs."

"One flaw in the original study," she continues, "is that the researchers never defined how many steps make up a flight of stairs; nor was there a standard measure for the pace at which the stairs were to be climbed."

The new study set out to determine if the energy costs on the heart for stairclimbing were actually similar to energy costs for sexual activity. For her study Elster used a comparable group of middle-aged males with a similar history and degree of heart disease. "We used the criteria that two flights of stairs contained 24 steps with a landing

between the flights; that the total rise of the two flights was 12 feet 8 inches; and that a 'brisk' pace meant a rate of 130 steps per minute, or 10 seconds in which to climb the two flights."

When the results of stairclimbing tests were tabulated, reports Elster, the average maximal heart rate was 104 beats per minute. The 1969 maximal heart rate for sexual activity, however, averaged 117.4 beats per minute, a figure obviously higher than that incurred in brisk stairclimbing.

Although two different groups of subjects were compared in Elster's study, they had been matched as carefully as possible and had both been drawn from among patients who had been involved in an exercise rehabilitation program for similar lengths of time.

Cautions Elster: "Until further data are available, it should be kept in mind that the maximal heart rate during sexual activity may exceed that reached during stairclimbing. If this is the case, the patient should not resume sexual activity just because he is able to climb any two flights of stairs without ill effects."

Whatever decision the patient makes, stresses Elster, it should be based not only on a stairclimbing test, but also on open discussion between the patient and his doctor or nurse.

Health happenings

Researchers at the Duke University Medical Center in the U.S. have concluded that 45 percent of all heart attack victims could be sent home from hospital in one week instead of the current average of more than two weeks. Early release, according to the doctors who carried out the study, would aid the psychological recovery of these patients and save the country millions of dollars in medical costs.

In their study, the researchers followed the medical progress of two groups of heart attack victims — one that went home after a week and another that was discharged after 11 days.

Their outcomes were identical. No one in either group had serious heart trouble within six months of discharge.

"Such low-risk patients can be spared the economic and psychological stress of prolonged hospitalization," the study concluded.

Orthopedic nurses hold second national meeting

Over 500 nurses met in Toronto in early February for the two-day Canadian Orthopedic Nurses Conference. Although most of the nurses attending came from Ontario, there were also representatives from Newfoundland, Nova Scotia, Alberta, British Columbia and the United States.

Norma Hair, president of the Association and head nurse of the operating room at the Orthopedic and Arthritic Hospital in Toronto, began the conference by tracing the growth of the organization since its modest beginnings only four years ago. The group has grown from a local interest group to one with nation-wide membership. Last February marked the first all-day meeting of the orthopedic nurses and that meeting's success prompted plans for the two-day meeting this year.

The focus of this second conference was on meeting the special education needs of orthopedic nurses. Highlights included:

- a discussion of Hemophilia and the Orthopedic Patient by Dr. Peter McClure from Toronto's Hospital for Sick Children. Dr. McClure talked about the prophylactic role of cryoprecipitate in preventing bleeding into joints. He also discussed the role of the home care programs in encouraging children with hemophilia to care for themselves and avoid complications.

- Dr. William Cummings a radiologist from HSC discussed the interpretation of back and knee X-rays using slides to show the audience exactly what they were looking for in examining an X-ray.

- Melanie Hitch the founder of the Toronto Interest Group that later grew to become the Canadian Orthopedic Nurses group, gave an interesting presentation about nursing assessment of the patient with back pain. Her discussion was illustrated with very specific and helpful slides. Melanie was working at Sunnybrook Medical Centre when she organized the group. She now works as an Orthopedic Nurse Clinician in Denver, Colorado.

- Dr. Walter Bobetchko and Dr. Morley Herbert of the Hospital for Sick Children talked about the new role of Electro-spinal Instrumentation in the early treatment of scoliosis.

The first day of the conference wound up with a panel discussion by the Toronto Back Education Unit of the Toronto General Hospital. Each member of the panel discussed the individual and group approach to the problems brought on by chronic back pain. The Education Unit uses small group discussions with patients who have back pain to teach them about their backs, how they can take care of themselves, how they can be more aware of the importance of their emotions as they relate to their bodies and back pain.

Did you know ...

"Children Can't Fly" is a health education program developed by the New York City Department of Health to combat the high incidence of mortality and morbidity due to falls from windows. Begun in 1972, the program has brought about a significant reduction in falls, particularly in the Bronx where falls declined by 50 percent between 1973 and 1975.

The program has four major components:

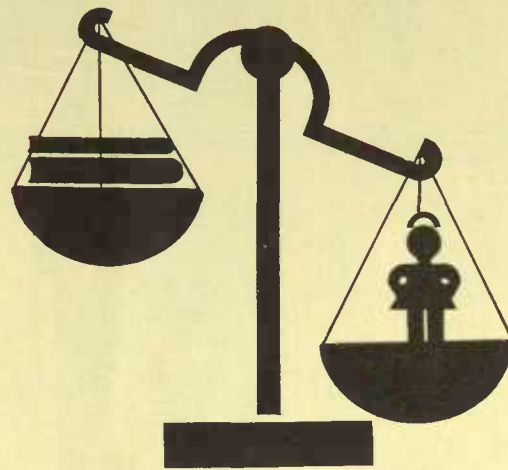
- 1) reporting of falls by emergency rooms and police precincts, followed up by counseling, referral, and data collection by public health nurses;
- 2) a media campaign to inform the public and elevate their awareness of the hazards;
- 3) community education for prevention;
- 4) provision of free, easily installed window guards to families with young children living in high risk areas.



**Canadian Nurses Association
1978 Annual Meeting
and Convention**

**25-28 June 1978
Toronto, Ontario**

YOU AND THE LAW



The legal significance of charting

"T.P.R. and B.P. q 1/2 h" and the Supreme Court of Canada

Corinne L. Sklar

X What is the legal significance of the entries that you, as a nurse, make on your patients' charts?

The decision of the Supreme Court of Canada in the case of *Joseph Brant Memorial Hospital v. Koziol*, (1977), underscores the importance, both medical and legal, of the nurse's recording. In that case, the 36-year-old male patient underwent spinal fusion for an injury received in an automobile accident. Post-operatively, he was returned to the surgical unit unconscious and on a Stryker frame. The next morning he was found dead.

The patient's family sued the hospital, the nurses and the surgeon. The trial judge found that death had ensued from aspiration of gastric juices. This was caused by a failure to render proper post-operative nursing care. The Ontario Court of Appeal and the Supreme Court of Canada concurred in the finding of liability against the hospital and the nurse caring for the patient. Charges against the other nurses were dismissed.

It is important to note that the court found no negligence on the part of the surgeon. In fact, the trial court found that the surgeon was "entitled to rely on the hospital and its staff in the management of the post-operative care of his patient and that when they accepted his patient they would without negligence care for him."

In this case, the chart was important both for what was recorded and for what was not recorded. The record was clear of entries from 10:00 p.m. until early the next morning (5:00 a.m.), when the patient died. There had been no entry of the patient's vital signs, nursing observations or care given. When she reviewed the chart later, the assistant director of nursing instructed the nurse involved to record the observations which she claimed to have made but had not recorded. The trial judge commented adversely:

"One is always suspicious of records made after the event, and if any credence is to be attached to ex. 29 (the later-entered note), it shows that at all times the patient was quite pale, very pale, and was allowed to sleep soundly to his death."

The nursing notes were introduced as evidence and the absence of entries recording nursing care permitted the inference that "nothing was charted because nothing was done." The court then compared the nursing care the deceased was alleged to have received with the post-operative care he reasonably should have received. The absence of entries during the crucial period determined the liability of the hospital and the nurse.

The chart: a history of patient care

The patient's record is a written account of his illness (or state of health) and treatments by all members of the health team. This applies to hospitalization or visitation to any other institution (e.g. a clinic) or to a private physician's office. The record serves both as identification and as a written history of the patient's care. The nurse's notes are an integral part of the patient's record. They provide a history of all medical treatments ordered and carried out, and all nursing measures carried out on behalf of the patient. A dynamic picture of the treatment received by the patient is drawn through the recorded observations of the nurses. Thus, the patient's appearance, verbalizations, responses to treatments and observations of the specific affected areas are most important in assessing and planning patient care. They also are relevant in later determining the quality of care given. The fact that entries are signed or initialled by the nurse involved serves to identify the giver of care.

The record is used as a source of information which serves as a basis of the patient's care and treatment. (Canadian Hospital Law: A Practical Guide, L. Rozovsky) As the trial judge quoted with approval,

"Medical records are an important tool in the practice of medicine. They serve as a basis for planning patient care; they provide a means of communication between the attending physician and other physicians and with nurses and other professional groups contributing to the patient's care; they furnish documentary evidence of the course of the patient's illness, treatment and response to treatment. Very importantly in the accredited hospital, they serve as the basic document for the medical staff's review, study and evaluation of the medical care rendered to the patient. For these reasons the Canadian Council on Hospital Accreditation considers the quality of medical records not only an important indication of the quality of patient care given in a hospital, but a valuable tool to maintain quality care and promote staff education."

Since medical records specifically reflect patient care, Council evaluates a medical record on the basis of whether or not it contains sufficient recorded information to justify diagnoses, warrant good treatment and explain the reasons for the end results. In agreement with this principle, the accreditation program has established Standards for record keeping which are regarded as being essential for the assurance of good patient care in the hospital."

The record's value is not diminished by the patient's discharge or death; the record is still retained by the hospital (or institution). This is usually required by provincial statute and the statutory regulations detail what should be retained and for how long. These requirements vary from province to province. One of the reasons for retaining the record is to provide an answer to an action brought by a patient or his family. It is in this area that the quality of the record determines liability.

Establishing liability

In the case referred to above, the courts, on the basis of testimony by expert nurses, agreed on what they considered an acceptable standard of nursing care for a post-operative patient. This standard includes coughing and deep breathing, recording vital signs, checking the bladder and catheterization if necessary.

The Supreme Court established the liability of the nurse and of the hospital on the basis of the conduct of the nurse as recorded in the note that she made later, to the effect that the pale, pale patient had been permitted to sleep all night.

This course of conduct was "absolutely contra the course of treatment advised by the medical witnesses and the nursing expert witnesses." The absence of any charting permitted the inference that no care had been given — clearly against good nursing practice. Moreover, even an entry of dubious credibility, when considered and compared with the expected standard of care, showed that the care alleged to have been given fell short of the acceptable standard.

Do's and Don't's of charting

In a 1970 case, the Supreme Court of Canada declared that, in the case of a legal dispute, nurses' notes should be taken into account in determining what actually occurred:

"Hospital records, including nurses' notes made contemporaneously by someone having a personal knowledge of the matters then being recorded and under a duty to make the entry or record should be received as prima facie proof of the facts stated therein."

When it comes to charting, nurses should be aware of the dangers involved in certain fairly common practices:

- Pooling observations towards the end of a shift, for example, or recording information for a colleague casts a shadow on the validity of the record.
- Omitting routine events from charting can also be dangerous. What is routine for patient A may be, for patient B, a symptom necessitating medical or nursing action.
- Erasures can also create doubts about the validity and credibility of recordings. When you make a mistake on a chart, you should draw a line through the error, make a written indication of "ERROR," initial it and make the correct entry immediately after.

In short, nurses' notes should never be taken lightly and regarded as unimportant or merely routine. During a legal proceeding they can, and sometimes do, serve to either protect or convict the people involved.



"You and the law" is a monthly column that appears for the first time this month in The Canadian Nurse. Columnist Corinne Sklar is a nurse, third-year law student and also the author of "Legal consent and the nurse" which begins on page 34 of this issue.

Next month: The patient's choice vs. the nurse's judgment.

Calendar

April

Getting Through to People — A two-day workshop to improve communication skills. To be held in Toronto on April 17-18. Tuition \$120. Contact: R.M. Brown Consultants, 1115-1701 Kilborn Ave., Ottawa, Ont. K1H 6M8.

Cancer Workshop to be held at McMaster University Health Sciences Centre, Hamilton, Ontario on April 7-8, 1978. Contact: Kathy Zimmer, Chairperson, Senior Nutritionist, Nutrition Services, Room 4E15, McMaster University Health Sciences Centre, 1200 Main St. West, Hamilton, Ontario, L8S 4J9.

Nursing and the Law presented by Lorne Rozovsky. To be held on April 8, 1978 in Brampton, Ontario. Contact: Coordinator, Inservice Education, Peel Memorial Hospital, 20 Lynch St., Brampton, Ont. L6W 2Z8.

Open House for the Educational Program for Nurses in Primary Care at McMaster University in Hamilton, Ontario. To be held April 5, 1978 from 1:00 - 5:00 p.m. Displays, audiovisual presentations etc. All those nurses interested in the program are welcome. Contact: Mona Callin, Director, Educational Program for Nurses in Primary Care, Faculty of Health Sciences, Nursing Division, McMaster University, 1200 Main St. W., Hamilton, Ontario, L8S 4J9.

Management of the Lower Extremity Amputee a one-day interprofessional course to be held at Selkirk College, Castlegar, B.C. on April 15, 1978. The aim of the course is to provide the most up-to-date information on all aspects of treatment for doctors, therapists and nurses. Topics to be discussed include: amputations and wound healing, fitting of prosthetics, pre and post-op physiotherapy, amputee gait and new research into prosthetics. Fee \$35.00. For information contact: Continuing Education Department, Selkirk College, Castlegar, B.C.

Day in Psychiatry — The Manipulative Patient to be held at McMaster University Health Sciences Centre in Hamilton, Ont., on April 12, 1978. Contact: Dr. M. Gooderham, Chairman, Chedoke Child and Family Centre, Chedoke Hospital, P.O. Box 490, Hamilton, Ontario.

Geriatric Medicine — to be held April 28 and 29, 1978 in the Dr. Vernon Fanning Extended Care Centre, Calgary, Alberta. For further information, contact: J. Lockyer, Division of Continuing Medical Education, The University of Calgary, 2920 - 24th Ave. N.W., Calgary, Alberta, T2N 1N4.

May

Conducting Performance Reviews — A two-day program for health care managers who conduct critical interviews with staff. To be held in Sault Ste. Marie, Ontario on May 8-9. Tuition \$120. Contact: R.M. Brown Consultants, 1115-1701 Kilborn Ave., Ottawa, Ont. K1H 6M8.

Annual Meeting of the Manitoba Association of Registered Nurses to be held at the Convention Centre, Winnipeg, Manitoba, on May 28-30, 1978. Theme: Professional Accountability. Contact: J.L. Cummings, MARN, 647 Broadway Ave., Winnipeg, Man., R3C 0X2.

New Brunswick Association of Registered Nurses Annual Meeting to be held on May 29-June 2, 1978 in St. John, N.B. Contact: NBARN, 231 Saunders St., Fredericton, N.B. E3B 1N6.

Health Care of Women and Infants for Community Health Nurses to be held in Lake Tahoe, Nevada on May 10-12 and in Tarpon, Florida, May 24-26, 1978. Sponsored by the Nurses Association of the American College of Obstetricians and Gynecologists. Contact: NAACOG, Department of Education, Suite 2700, One East Wacker Drive, Chicago, Illinois, 60601.

The Executive Nurse — A three-day program for nurses in management positions. To be held in Toronto on May 29-31. Tuition \$150. Contact: R.M. Brown Consultants, 1115-1701 Kilborn Ave., Ottawa, Ont. K1H 6M8.

Catholic Health Association of Canada 1978 Annual Convention to be held on May 11-13, 1978 at the Royal Connaught Hotel in Hamilton, Ontario. Theme: Aging — A time for growing. Contact: Catholic Health Association of Canada, 312 Daly Ave., Ottawa, Ontario, K1N 6G7.

Continuing education courses at The University of Toronto: *Nursing Process in Mental Health and Psychiatric Nursing* to be held May 3-5, 1978; *Stress Relieving Strategies*, planned in cooperation with the Operating Room Nurses' Association of Greater Toronto, May 4-5, 1978; *Writing Workshop for Nurses*, May 11-12, 1978; Contact: Dorothy Miles, Director, Continuing Education Program, Faculty of Nursing, University of Toronto, 50 St. George St., Toronto, Ontario, M5S 1A1.

Pediatric Intensive Care Conference to be held at The Hospital for Sick Children, Toronto on May 15-16, 1978. Medical and nursing presentations dealing with respiratory distress and congenital heart disease will be presented. Contact: Hilda Rolstin, Nursing Education, The Hospital for Sick Children, Toronto, Ont., M5G 1X8.

Care of the High Risk Fetus and Newborn. To be held on May 15-17, 1978 at the University of British Columbia in Vancouver. Theme: Fetal monitoring and nutrition in the newborn. Contact: The Division of Continuing Medical Education Instructional Resources Centre, The University of British Columbia, Vancouver, B.C. V6T 1W5.

June

Pediatric Audiology Workshop to be held at Queen's University in Kingston, Ontario from June 19-23, 1978. Lectures and practical training sessions are offered to public health nurses and registered nursing assistants from across Canada. Attendance limited to 15 persons. Apply before May 15 to: Paula Varette, Head, Division of Audiology, Nickle 2, Kingston General Hospital, Kingston, Ontario, K7L 2V7.

Surgical Knots and the RNA. A one-day surgical nursing seminar specifically designed for registered nursing assistants interested in the O.R., R.R., E.R. and medical-surgical areas. To be held on June 16, 1978 in Toronto. Contact: Conference and Seminar Services, Humber College of Applied Arts and Technology, P.O. Box 1900, Rexdale, Ont., M9W 5L7.

Pain: A Nursing Concern to be held on June 6, 1978 in Toronto, Ontario. Contact: Dorothy Miles, Continuing Education Program, Faculty of Nursing, University of Toronto, 50 St. George St., Toronto, Ontario, M5S 1A1.

Did you know ... Graduates of Port Arthur General School of Nursing, Thunder Bay, Ontario, Class of '68 — **ten year reunion** is being planned on June 23-24, 1978. Contact: Carol Readman, R.R. 12, Mapleward Rd., Thunder Bay, "P", Ontario, P7B 5E3.

Saint John General Hospital is planning an alumnae reunion in 1978. If interested please contact: S.J.G.H. Alumnae, P.O. Box 6111, Station A, Saint John, N.B. E2L 4R5 Please enclose name, year of graduation, and correct postal address.

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100	METAL FRAMED... Smooth plastic background with classic, distinctive polished metal frame. Beveled and rounded edges and corners. Smart professional appearance.	Frame: <input type="checkbox"/> Gold <input type="checkbox"/> Silver	<input type="checkbox"/> White <input type="checkbox"/> Green <input type="checkbox"/> Blue <input type="checkbox"/> Brown	<input type="checkbox"/> Black <input type="checkbox"/> Dk. Blue <input type="checkbox"/> White	2 Lines Lettering <input type="checkbox"/> 3.69	<input type="checkbox"/> 5.99
559	PLASTIC LAMINATE... Slim, broad, yet lightweight. Engraved through surface into contrasting core color. Beveled border matches lettering. Excellent value.	<input type="checkbox"/> White <input type="checkbox"/> Med. Green <input type="checkbox"/> Med. Blue <input type="checkbox"/> Cocoa	<input type="checkbox"/> Black <input type="checkbox"/> Dk. Blue <input type="checkbox"/> White	1 Line Lett. <input type="checkbox"/> .99	<input type="checkbox"/> 1.74	<input type="checkbox"/> 2.49
510	MOLDED PLASTIC... Simple is smart. Smooth clean plastic deeply engraved, lacquer-filled. Edges and corners gently rounded. The original nurse style... always correct.	<input type="checkbox"/> White <input type="checkbox"/> Dk. Blue <input type="checkbox"/> Dk. Green	<input type="checkbox"/> Black <input type="checkbox"/> Dk. Blue <input type="checkbox"/> White	1 Line Lett. <input type="checkbox"/> 1.49	<input type="checkbox"/> 2.49	<input type="checkbox"/> 3.69

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No. 4500 4 1/2" Stainless 2.95
No. 5500 5 1/2" Stainless 3.25
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A look at the Canadian Nurses Association, how it operates and what it does for you

This is YOUR Association!

Beryl Darling

The last time you wrote a cheque entitling you to membership in your provincial nurses' association, did you think about how that money would be used? Most of it, of course, goes towards meeting the operating expenses of your own provincial association but *some* of that money — and the amount varies, depending on which province you live in — is passed along to your national association. And CNA, in turn, passes some of it along to the organization that represents nursing on a world-wide basis, the International Council of Nurses (ICN).

How much does it cost you to belong to CNA? The answer is complicated by the fact that the affiliation fee in each province is based on a sliding scale, with the final figure determined by the size of its membership. If you live in the Northwest Territories, for example, your association passes along \$9.00 per member to the national association. At the other end of the scale, if you live in Alberta, the CNA fee per member is \$17.55. For a look at where *your* province stands on the sliding scale, see Table one.

That's why, although it is quite true that the 1978 Unit Fee approved by CNA members two years ago is \$18.00, it is also true that not one of the eleven member associations will hand over \$18.00 per member to the national association this year. The sliding scale on which the unit fee is based is as follows:

1/2 unit 1st 250 members
3/4 unit 251 - 1000 members
1 unit 1,001 - 15,000 members
3/4 unit 15,001-25,000 members
1/2 unit 25,001 plus

The ceiling for the payment of fees (for an association member) shall not exceed 1/3 of the CNA fee income for the previous year."

In 1975, when the unit fee system was introduced, the unit fee was \$10.00. That year the association actually received \$8.06 per individual member. This year, with a unit fee of \$18.00, CNA can expect to realize \$14.24 per individual nurse member — provided that membership in the provinces/territories remains the same as it was in 1977. Total CNA fee revenue for 1978, then, based on 1977 actual membership figures, is expected to be \$1,739,474. (See Table one). (A significant decline in membership in any one provincial/territorial association during 1978 would, of course, result in reduced revenue for the national association).

Out of this \$1,739,474, the association will transfer approximately \$153,851 to the International Council of Nurses, (2.2 Swiss Francs per individual CNA nurse member or \$1.25 at current exchange rates). When these ICN fees are deducted from the amount that CNA will receive in 1978 from each nurse, (\$14.24) the association is left with \$12.99 per member out of the original unit fee.

Until two years ago, when CNA members voted to increase the unit fee to \$12.00 in 1977 and \$18.00 in 1978, the national association had been historically almost immune to inflation. (See Table two).

Table two

Actual CNA membership fee * received per individual nurse member

1961 — 1966	\$ 6.00
1967 -	\$ 8.74
1968 -	\$ 8.65
1969 -	\$ 8.42
1970 -	\$ 8.82
1971 -	\$ 8.56
1972 -	\$ 8.55
1973 -	\$ 8.55
1974 -	\$ 8.53
1975 -	\$ 8.06
1976 -	\$ 8.77
1977 -	\$10.03
1978 -	\$14.24 **

* (including ICN Affiliation Fee)

** projected on 1977 membership figures

Looking at this table it becomes obvious that throughout the ten-year period between 1967 and 1976 per capita income remained almost unchanged; in fact, in some of those years it actually *decreased*. This situation, which would be difficult at the best of times, became completely untenable during the recent inflationary trend.

In the light of these figures, it is not surprising to learn from the audited financial statements on the next three pages that last year the association incurred a deficit of \$151,362. This year, with the introduction of zero growth budgeting and the curtailment of some member services, CNA hopes to operate in the black.

What will you get for your \$14.24 this year?

A pamphlet prepared by the association lists the following CNA services:

Liaison

As the national spokesman for more than 122,000 professional nurses, CNA maintains liaison with many departments of the federal government and more than 100 health-related organizations or agencies. Liaison activities include: official CNA representation on external committees, conferences, task forces and working parties; consultation on request; presentation of briefs and submissions to governmental and non-governmental agencies; membership participation in various national and international organizations; a shared directing role for programs such as the Extension Course in Nursing Unit Administration and joint meetings of officers of the Canadian Hospital Association, the Canadian Medical Association and the Canadian Nurses Association.

Research and Advisory

This unit carries out studies assigned by the board of directors and collects and analyzes data on new trends and significant developments affecting the nursing profession. This information serves as a basis for national statements and representation to governmental and non-governmental agencies.

The unit also collects and processes national nursing statistics. Information collected by the unit is also used in the preparation of briefs and submissions.

Table one

Membership, provincial fees and CNA fee revenue by province/territories

Member Association	Number of members	Provincial fees - 1978 (active practising member)	CNA 1978 fee per member *	CNA 1978 budget revenue (\$18.00 unit) *
B.C.	16,629	\$100.00	\$17.22	\$286,366
Alta.	12,518	60.00	17.55	219,699
Sask.	7,169	75.00	17.21	123,417
Man.	7,468	70.00	17.24	128,799
Ont.	18,750	75.00	16.80	315,000
Que.	43,899	80.00	9.29	408,245
N.B.	4,723	65.00	16.59	78,389
N.S.	6,338	80.00	17.11	108,459
P.E.I.	942	70.00	12.30	11,592
Nfld.	3,521	60.00	16.39	57,753
N.W.T.	195	100.00	9.00	1,755
Total	122,152		14.24	1,739,474

* based on 1977 actual membership fees.

Information

The information program of the association accumulates, processes and distributes nursing information to promote understanding and acceptance of CNA policy among members of the nursing profession, allied groups and professions, government agencies and the general public. To do this, it employs all available media including its own monthly publications, *The Canadian Nurse* and *L'infirmière canadienne*. These magazines, which have a combined monthly circulation of more than 130,000, provide comprehensive coverage of nursing activities as well as general and technical articles of interest to the nursing profession.

Library

Originally developed to support the research and consulting activities of the association, the CNA Library has become Canada's only national nursing library. A collection of more than 13,000 books and documents and more than 450 periodical titles — in English and French — together with the national Repository Collection of Nursing Studies, make it one of the most comprehensive nursing libraries on this continent. The loan and reference departments serve CNA members in Canada and abroad.

International Cooperation

As a member of the International Council of Nurses, CNA is responsible for representing Canadian nurses at the international level and for communicating with other international organizations active in the health field.

CNA participates in the ICN Nursing Abroad program which facilitates the mobility of nurses from one country to another for periods of study or observation. Visits of nurses from ICN member-countries are arranged by CNA with the cooperation of association members and nursing associations throughout the world. In addition, CNA helps Canadian nurses who are seeking employment or study abroad.

CNA cooperates with governmental and non-governmental agencies such as the World Health Organization, the Pan American Health Organization, the Canadian International Development Agency, the Canadian University Services Overseas and the Canadian Red Cross Society.

Labor Relations

This newly developed unit of CNA has been established to provide labor relations services to all CNA members, provincial/territorial bargaining organizations and others. Initially, these services will include collection and analysis of data and distribution of information. Educational programs and research activities are now being developed.

Testing Service

CNA maintains a National Testing Service which prepares machine-scored objective-type examinations in English and French for graduates of nursing programs who are seeking registration. The service is available to all registering and licensing authorities for both nurses and nursing assistants.



Beryl Darling is director of administrative services for the Canadian Nurses Association.

Canadian Nurses Association
Financial Statements and Auditors' Report
Year ended December 31, 1977

Canadian Nurses Association
Balance Sheet
December 31, 1977

	Assets	1977	1976
Current Assets			
Cash in bank		\$ 115,073	\$ 147,592
Short term deposits plus accrued interest		170,234	211,770
Accounts receivable		37,028	44,314
Membership fees receivable		2,694	17,788
Prepaid expenses		18,690	10,968
		<u>343,719</u>	<u>432,432</u>
Sundry Assets			
Marketable securities — at cost		6,044	4,933
Loans to member nurses plus accrued interest		13,420	10,093
		<u>19,464</u>	<u>15,026</u>
Fixed Assets — note 1			
CNA land		148,225	148,225
CNA building		637,343	637,343
		785,568	785,568
Less accumulated depreciation		361,236	329,369
		424,332	456,199
Furniture and fixtures — at nominal value		1	1
		<u>424,333</u>	<u>456,200</u>
		<u>787,516</u>	<u>903,658</u>
Liabilities and Surplus			
Current Liabilities			
Accounts payable and accrued liabilities		\$ 34,903	\$ 18,459
Deferred revenue — subscriptions		35,600	35,300
		<u>70,503</u>	<u>53,759</u>
Grants for Special Projects — unexpended portion — note 2		48,421	29,945
Surplus		668,592	819,954
		<u>787,516</u>	<u>903,658</u>

Approved on behalf of the Board:

Joan Gilchrist, *President* Dr. Helen K. Mussallem, *Executive Director*

Canadian Nurses Association Statement of Income and Surplus

Year ended December 31, 1977

	1977	1976
Revenue		
Membership fees	\$ 1,224,735	\$ 1,014,066
Subscriptions	53,435	39,196
Advertising	317,537	306,952
Sundry Income	4,649	4,923
Investment income	31,390	50,847
	<u>1,631,746</u>	<u>1,415,984</u>
Expenditures		
Operating expenses:		
Salaries	835,867	796,680
Printing and publications	327,247	292,735
Design and graphics	31,770	23,835
Postage on journal	162,486	126,601
Computer service	46,074	45,835
Committee travel	32,403	25,247
Commission on advertising sales	43,599	39,117
Affiliation fees — I.C.N.	106,053	96,175
— Canadian Council on Hospital Accreditation	14,000	6,000
Professional services	22,821	24,762
Travel — non-committee	23,670	15,566
Office expense	46,107	36,690
Books and periodicals	12,427	9,820
Legal and audit	8,206	7,950
Building services	82,547	77,838
Sundry	5,607	6,052
Furniture and fixtures	11,795	1,387
Property improvements	1,200	6,900
Depreciation — CNA House	31,867	31,867
Insurance	2,358	2,043
General meeting	3,255	—
Contingency for special projects	14,900	1,177
	<u>1,866,259</u>	<u>1,674,277</u>
Non-operating expenses		
1976 convention	—	(13,680)
Support services allocated to CNA Testing Service	1,866,259 (50,245)	1,660,597 (51,992)
	<u>1,816,014</u>	<u>1,608,605</u>
Surplus (Deficit) for year before items below	(184,268)	(192,621)
CNA Testing Service — per statement	32,906	170,494
Surplus (Deficit) for year	(151,362)	(22,127)
Surplus at beginning of year	819,954	842,081
Surplus at end of year	<u>668,592</u>	<u>819,954</u>

**Canadian Nurses Association
Statement of Income — Testing Service
Year ended December 31, 1977**

	1977	1976
Revenue		
Examination fees	628,067	649,896
	<u>628,067</u>	<u>649,896</u>
Expenditure:		
Salaries	263,059	242,230
Committee meetings	57,373	24,192
Item writing	58,615	10,237
Operations (data processing, printing and warehousing)	97,062	89,065
Consultants	1,609	—
Rent	39,030	37,002
Translation	2,433	1,342
Office supplies and stationery	8,342	6,242
Postage and express	4,479	3,040
Telephone and telegraph	4,507	5,160
Travel — non-committee	2,667	3,164
Equipment maintenance and rental	2,105	1,996
Books and periodicals	2,535	1,226
Furniture and fixtures	575	2,054
Miscellaneous	525	40
Insurance	—	420
	<u>544,916</u>	<u>427,410</u>
Support Services	<u>50,245</u>	<u>51,992</u>
	595,161	479,402
Surplus (Deficit) for year	<u>32,906</u>	<u>170,494</u>

Auditors' Report

To the members of Canadian Nurses Association

We have examined the balance sheet of Canadian Nurses Association as at December 31, 1977 and the statement of income and surplus for the year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests and other procedures as we considered necessary in the circumstances.

In our opinion these financial statements present fairly the financial position of the Association as at December 31, 1977 and the results of its operations for the year then ended in accordance with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Geo. A. Welch & Company,
Chartered Accountants.

January 20, 1978

Canadian Nurses Association Notes to Financial Statements

December 31, 1977

1. Fixed Assets

It is the policy of the Association to expense purchases of furniture and fixtures in the year of purchase.

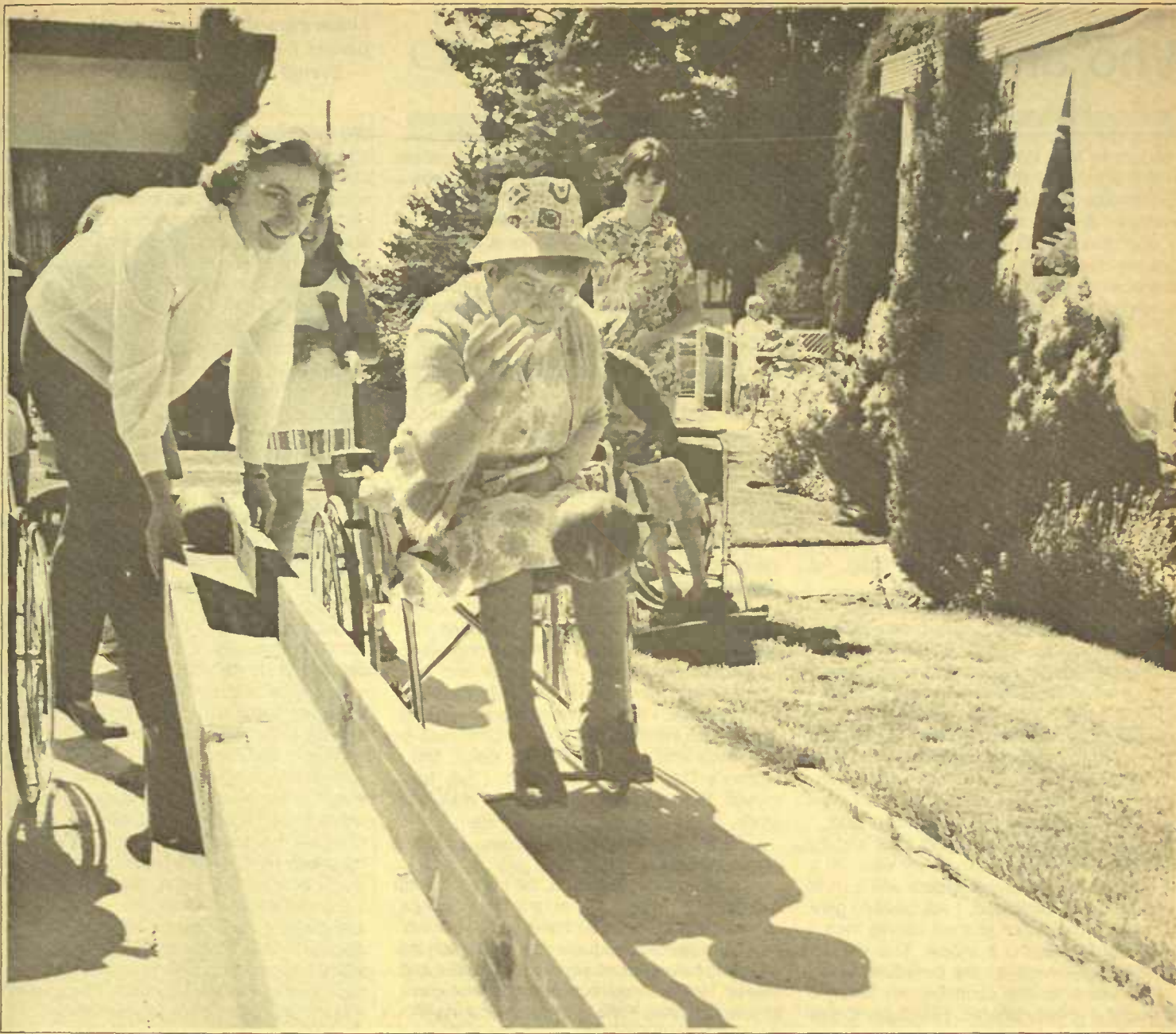
The CNA House is being depreciated over 20 years at the rate of 5% per annum.

2. Grants for Special Projects

The Department of Health and Welfare and the Canadian International Development Agency advances funds to the Association in respect of grants for special projects. The unexpended portion of these grants at December 31, 1977 totalled \$48,421.

3. Retirement Income Plan

At the beginning of 1975 changes were made to the Association's retirement plan resulting in additional benefits for past service. Actuaries have estimated that an annual amount of \$38,500 for the next 12 years will be required to fund the past service benefits.



Freedom to be

a new approach to quality care for the aged

Vera McIver

In Canada, restorative care for the aged based on quality is still far from being a reality. We continue to pattern our extended care settings after acute care hospitals, placing heavy emphasis on meeting residents' physical requirements but neglecting their psychosocial needs. The Priory Method, as it was developed at The Priory in Victoria, B.C., and as it exists now at the four extended care hospitals operated by the Juan de Fuca Hospital Society (The Priory, Mt. Tolmie, Glengarry and Aberdeen), is based on the belief that the elderly person is still a unique person working towards growth and self-fulfillment, and that a therapeutic and restorative environment can be achieved if this attitude is kept in mind.

Part one

Who am I?

I am a unique person and must have the "freedom to be." What makes me unique? I am the sum total of all my attributes and experiences. Through the years, I have developed a cultural role as prescribed for my age, sex, social role and profession. I have my fair share of conscious and unconscious attitudes, biases and prejudices. My uniqueness comes from my past, my ethnic and religious background, as well as from the choices I have made. Finally, I am here now trying to express the person I am.

I am still productive and still climbing Maslow's hierarchical ladder toward self-actualization; I am "no longer motivated by needs of safety, belongingness, love, status and self-respect because these needs have already been satisfied".² I am free for further growth and development, especially as it relates to my work with the aged. As long as I am physically healthy, psychologically mature and socially concerned, I can gain some measure of success in my work and, in the process, I experience independence and contentment.

But what will happen to me when I'm forced to retire? Will my past work-oriented behavior allow me to be content dusting the house? Will my reduced funds allow my past extravagances? Will my relationships with my working associates remain intact? I think not. I will be denied the admiration and affection of my colleagues and staff and the exhilaration I experience from my work. In a few weeks, my enforced leisure will turn to boredom. In all likelihood, I will have to give up my car. And, since women outlive men, I will probably become a widow. This will add grief and loneliness to my boredom.

As these losses continue, my lifestyle will become greatly altered. I will have to sell our home in the country, along with our beautiful horses and many mementos and treasures. How does one decide what must go and what to keep for a small suite in an apartment? In this social crisis, I find myself beset with denial, depression and stress so powerful that I do not hear what is said. I am so preoccupied with anxiety, I cannot remember the simplest detail. What did I do this morning? It's gone. I am frequently embarrassed because of this loss. I feel so useless. Casual observers see this behavior as symptoms of senility.

My old friends aren't around to comfort me as they, too, are sick or dead. This produces the threat that I could be next. I do not want to die.

My daughter and her husband belong to the jet set and are always in flight. My brothers and sisters, all older than I, are deceased. My neighbors are kind and look in briefly, but they, too, are preoccupied with their own problems. I live with my losses.

My hearing deteriorates as does my eyesight. These new losses further separate me from my environment. My hearing plays tricks on me; I only grasp a phrase or two and so my imagination runs off on a completely unrelated topic. As a result, people avoid these encounters because they see this as a symptom of mental confusion. I live in solitude. I feel rejected and devalued, but I don't know why. I have not had a personal failure. I'm still the same person. I still crave a successful, satisfying social life in which I see myself playing the role of mother and hostess. "It is human to want to be wanted, to yearn to be liked."³ I try to tell the postman about my very clever and beautiful daughter but he says he's too busy to stay. Finally, my unfulfilled human needs and deprivations change my personality because my path towards self-fulfillment is thwarted at every turn. I no longer live in a gratifying atmosphere.

No one enjoys eating alone, so I settle for tea and toast. I am in a constant quandary over my pills; I either neglect to take them or I repeat the dosage and then worry I might have a heart attack because of the overdose. I begin to have blackouts, I fall easily. The kettle burns dry, the pots melt on the stove and I burn the dish towel. My Mother's Day plant is withered. I talk to myself. I cling to memories; some make me smile, some are filled with regrets.

Then one day the door closes. I am in a nursing home.

Now I must rely on you, the nurse, to help me express the person that I am. But you are a unique person too. You have had your own particular past and experiences and along the way, you have formed your own attitudes and biases. How will you receive me when I arrive at your doorstep? Will you stereotype me with the many myths society applies to the aged; that all aged are alike, older people can't make decisions, a disability is an illness, old age is second childhood, most old people are in poor health, etc? If you subscribe to these myths I am doomed, because all your actions will reinforce me towards that end. Are you genuinely interested and socially sensitive to the welfare of people? Are you mature enough to embrace me with love even though my hair is unkempt, my clothing soiled and my mind confused? I will feel insecure, anxious and unsure of my abilities. Will you understand my fundamental needs? Maslow states that "psychological needs of safety, love, self-esteem and self-actualization have to be assured."⁴ If these yearnings are not understood and you disturb or twist my course toward self-actualization, you produce psychopathological distress. I must be set on the right course so that I can again develop as I was destined to.

My accompanying diagnosis says senility.

I am a unique person.

I must experience the world and express the person I am.

— Everett L. Shostrom¹

Will you see senility as synonymous with old age and illness, or will you see it as possibly a deviated behavior due to my many physical, social and psychological losses? My confusion could be due to malnutrition, poor drug therapy, an undiagnosed illness, or merely my high score of social deprivations.

What message will the physical aspects of your nursing home convey to me? Is it a mini-hospital patterned after an acute care hospital, complete with nurses in full white uniform to further intensify the "institutional" aura? In this facility, I will be molded into the prefabricated shell of a patient even though I may still have many strengths and capabilities which could be improved or restored.

What sort of organizational structure will you have? Will you cling to the traditional medical model? Is it a bureaucratic maze of red tape? Will you indulge in an authoritarian leadership in which your roles demand respect? Within a pyramid will each department and each discipline be a little kingdom unto itself? Will medical staff remain aloof? Will nurses, even though they are capable of developing a restorative program, refuse to participate in rehabilitation because there are separate physio- and occupational therapy departments? Will the physiotherapist remain in her department waiting for orders without assuming any responsibility at the floor level? Is the dietary department inflexible within its own rigid system, making it difficult to initiate a therapeutic program? For example, must they have a week's notice to change the menu for a picnic? Then, what if it rains? Will the social worker fill her time with placements and neglect social care? Will one discipline discuss related problems with another, or even share a cup of coffee in friendship? In situations where this informality does not exist, a team approach is an impossibility.

Will your facility be controlled by rigid or piecemeal rules and regulations because you wish control or lack understanding? Will the rules, with their detailed procedures, rob me of my uniqueness? Will I be forced to adapt and conform to the non-person role and even learn to apply a grateful smile? Once you accomplish this, I become a "model resident," completely withdrawn, and nothing will be expected or required of me. Will neatness and order become an obsession such that the janitor is more important than the residents? Will furniture remain lined up against the wall for greater ease of cleaning, even though it curtails sociability? Will I be oversedated and restrained in order to maintain control and solve your problems? What about mine? Will I have to obtain permission from someone in charge for some mere request I have taken for granted for years?

For me to play the patient role in this facility, I am given a wardrobe and a stage. When I am admitted, my clothing is sent home

CROSSROADS



The following play describes a case that appears in a 20-minute film called "The Priory Method." This film has been used for educational purposes in Canada and the U.S. and was shown at the World Congress of the Gerontological Association in Jerusalem in 1974. For information on this film and how you may obtain it, see this month's Audiovisual department on page 50.

ACT I — Takes place in a general hospital.

A brief rundown on the cast:

The leading lady is an 80-year-old patient with a diagnosis of senility. A full complement of professional disciplines and stand-ins supports her. A physician, who briefly appears to prescribe pills, plays a minor role. An R.N. has a slightly more important role. She does all she can to meet the needs of the "total person" as she escorts the patient down the path to deterioration. At regular (but infrequent) intervals, she hastily appears to nurse the catheter or drop a pill into the patient's mouth. She makes a hurried retreat lest by chance she be detained by an idle remark which could lead her into conversation. Nonverbally, she has to convey, "I have far more important things to do than stand here wasting my time." The patient gets the message. Silence becomes a way of life. The stand-in attends to all other needs of the patient.

The patient has a very difficult role. Without the help of make-up, she has to portray deterioration. Physically, she has to change from an upright position to a contracted, grotesque form. Mentally, she has to depict impairment which, finally, leads to vegetation.

To aid and abet the lead in her performance, the nurse draws on the supporting cast of professional disciplines, since they are experts in this field. The patient vies for the limelight, and constantly seeks recognition and approval from her supporting cast. She reacts to the slightest cue.

The patient notices a victory smile on the face of the nurse every time she conforms to her wishes; with this encouragement, she finally gives a superb performance. Dialogue is no longer necessary. Deterioration can be depicted by incessant babbling. Even her body, with the help of contractures, has shaped itself into a pathetic fetal position. Her portrayal of vegetation is complete.

EPILOGUE:

The deterioration you witnessed can take place in any long-term patient when physical care receives priority and mental and social stimulation is neglected.

PROLOGUE TO ACT II:

At the end of Act I, the leading lady is in serious trouble, but there is a ray of hope. Ultimately, the patient will be deteriorated sufficiently to make her eligible for an extended care hospital. This is no mean feat; sometimes it takes 15 months of professional care.

ACT II

Scene I — Entrance hall of an extended care hospital.

Two ambulance attendants deposit the leading lady into a chair. What a performance! Her face is haggard and pinched, devoid of make-up, and her hair is unkempt. The scanty hospital gown does not hide the dangling catheter; in fact, she is shamefully exposed. Her knees are up under her chin, as she is now able to rest her feet on the seat of the chair. She is not wearing stocking or shoes. Two nurses have to assist her since she can only walk on her haunches. While she is being admitted, she babbles incoherently.

Scene II — Four months later. Recreational area of the extended care hospital.

Leading lady walks upright unassisted. She is fully dressed in becoming attire. A lovely hair style frames a beautiful face, which radiates pride and happiness. If one listens carefully, one can sometimes hear a structured sentence. She is no longer disturbed by the degrading catheter. She now has bathroom privileges. Dignity has been restored.

END

because there isn't enough storage space. I'm permitted to keep only a couple of nighties, dressing gowns and slippers. I will always be clad in night attire, completely confusing my concept of day and night. Meals will be served on a tray at my bedside, conveying punishment or illness. Toileting will also be done in my living quarters. I will be given a most humiliating and stressful vehicle, the bedpan. Instead of a tub bath I will be bathed out of a small hand basin.

Rather consider the opposite, and present me with a well role. My self-esteem will need to be rekindled. Have my clothing cleaned and subtly suggest that my wardrobe needs replenishing. Have my hair permed and set. See to it that my makeup is applied and that I'm always well turned out. Replace my worn-out slippers with attractive supporting shoes. Do not offer me the bedpan but give me bathroom privileges and have me bathe in a tub. Be sure to have washing arrangements and toilets close at hand and well marked. Toileting is a private ritual in our culture, and, if my privacy is denied by offering me a bedpan in my room or in the presence of others, I may not perform and may deliberately hold back through embarrassment. I may even become incontinent because of this.

In our culture, food is generally consumed with a certain ritual which is as necessary as the food itself. Encourage me to eat in the dining room seated at a well-set table. If I have forgotten how to feed myself, teach me and encourage good table manners. Find an amiable companion for me. Perhaps the opposite sex might prove beneficial in encouraging socialization. Adding a glass of wine will surely help.

Use consistency of approach in all areas that require retraining, and don't forget to give me rewards, smile at me or give me a nod of recognition. Please listen to me and don't rush by leaving my sentence suspended in mid-air. Your tone of voice, facial expression and gestures are very important, as they will convey your sincere interest to me far more than your words. When you are near me, please touch me. I must have this physical contact. It is a biological need. Stroking, petting and hugging are all signs of love and acceptance. Without these, I will wither and deteriorate.

Expect me to walk and exercise to regain my strength. Do not introduce me to the wheelchair until absolutely necessary, because it has been proven that confinement to wheelchairs for prolonged periods of time results in demonstrable personality deterioration. In a wheelchair I will feel trapped, my environment will shrink and I will be dependent on others; once again I lose control.

Be sure to follow the building code as it relates to the disabled in order to help maintain my independence. Avoid stairs and, if you must use ramps, be sure they are not too steep. Token considerations are often given these necessities, but errors are still made because the handicapped person was not involved in planning. We still find halls and

doors too narrow, bathrooms too small for wheelchairs, windows too high and elevator buttons out of reach.

Having been assigned to my area, I will begin to regard my room or the space around my bed as my territory. Once these boundaries have become firmly established, please do not change my accommodation without serious consideration of the consequences. Moving me from one room to another, or even switching my place at the table, will greatly upset me. Think of the damage done every time I am shunted from one facility to another, because my level of need changes. Whenever you alter my lifestyle by breaking relationships with former acquaintances and disturbing my space, you exact a heavy price. You create stress so serious that symptoms of mental deterioration are immediately evident.

Scientists also tell us that man deteriorates when he hasn't sufficient sensory stimulation. He tends to withdraw from reality. If you have used imaginative and thoughtful planning to provide me with an interesting and motivating environment, you will not have to set aside precious and valuable time later to contrive sensory stimulations, reality orientation exercises, and the numerous other activities designed to stem mental deterioration. Gay pictures, indoor and outdoor gardens, adequate space, patios, music, suitable and tasteful appointments, clocks, and beautiful, therapeutic colors will all encourage me to feel part of my environment. The outdoors provides tremendous exhilaration and the sun is a great therapeutic source. This free energy however, will not be used if too many obstacles are placed in the way. Such obstacles include limited staff, heavy portering in unwieldy chairs, and elevators and long corridors to unsupervised areas which make surveillance of the confused person an impossibility.

If I'm not interested in arts and crafts, please let me perform some other duties. Provide me with productive responsibilities. Perhaps I could shell some peas, prepare carrots, play the role of a postmistress or librarian. I must do something to occupy my mind and hands in order to re-establish some former feelings of usefulness.

In order to learn to care for me as a person, you must learn to know me, so that you are not dealing with a stranger. A comprehensive questionnaire would help you become acquainted with me. It could include such things as — personal history, prior living arrangements, general personalities, personal problems, sensitive areas, social attitudes, hobbies and interests, family relationships, childhood, socioeconomic, cultural and religious factors, present awareness and psychological orientation. Once this documentation, along with a total physical examination is compiled, you will find my uniqueness emerge. You will see how I experience the world, and how I am trying to express the person I am. Once you know me, you will be able to set goals for my improvement, but only if every staff member is aware of this information.

Despite my disability I still need to have the right to be self-directing in order to feel worthwhile. This right can be initiated into your program in many subtle ways. Let me help you set my goals as a member of your conference. Within my limitations, allow me to be self-sufficient in all activities of daily living. Let me choose the dress I would like to wear, and allow me to keep my jewellery and trinkets. When I go shopping, allow me to choose and pay for the dresses and shoes I select. These are small steps, but so necessary for my well-being.

As a member of a Resident Council, I could participate in directing the care given. The Council could plan activities which become more meaningful because of our involvement and because as a group, we decide which programs appeal to us. Staff need not feel threatened by this; it can become a very useful tool and it will often identify with administration if residents know the problems involved. There is much wisdom to be tapped, but it must be solicited.

Do not remove all my familiar objects. If the doll I brought with me is a comfort to me, why not leave it until you have brought me back to reality, and I am again able to enjoy my own keepsakes. Personal possessions provide comfort, security, satisfaction and aid memory. Send for my family album and treasures if I have not brought them, and encourage me to write my autobiography or make scrapbooks of my past. These activities will give me the opportunity of telling my story over and over so that, in the end, I will have things to talk about other than how clever and pretty my daughter is.

I will have a strong desire to leave a legacy, something of myself, so I won't be forgotten. A close friend will provide a sense of continuity and give me a feeling that someone will remember me. Invite children and let me talk to them so that I can share my accumulated knowledge. Perhaps I can tell them of my past experiences and, just by chance, they might find them interesting and even valuable. Think of my self-esteem.

I will begin to realize my end is drawing near and I will value time more. I will be living in the here and now. Have my priest come to see me so that I can set my books straight. There may be some conflicts which need to be discussed and resolved, but don't allow me to dwell on my approaching death. Provide me with stimulating activities. My creativity and curiosity will not decline. Before I go, I should have a sense of fulfillment and a feeling of satisfaction and serenity. When I reach the critical stage of death, remember that I still have feelings, desires, opinions and the need for love. Don't place me in isolation where I must exist in an impersonal and inhuman manner, as if I were already dead. Be sure you recognize Dr. Kubler Ross's five stages of death⁵ and, when I finally reach out and accept these stages, please understand me and be there to support me so that I can die with dignity and self-respect. I will then remain a unique person to the end. ♡

Part two

"Much about old age is not known but infinitely more is known than is applied."

— Dr. Robert Butler¹

The Priory Method



How many nursing home residents, if they had the courage to speak up and the insight into the nursing profession to question rules, would make such a plea? Are our extended care environments places where life is encouraged, or are they institutions where the aged await death in isolation and grief? In my work with the aged, I have seen too many "unique persons" who have the potential for some kind of recovery despite their disabilities but who, after some months in a hospital setting, were reduced to a fetal position and robbed of their remaining life and vitality. I have seen this, acknowledge the part my profession plays in it, and, over time, I have become an activist.

Although we are taught rehabilitative nursing, we seem unable to put it into effect; how to deal with a unique person's dignity and self-worth continues to baffle us. Twentieth-century advances in medical technology have changed the character and environment of the hospital, and made of the nurse a technical expert. Compared with the difficulties and struggle involved in comforting our patients' frustrated and battered psyches, this change in focus to life-saving and life-prolonging technologies is reassuringly concrete. And with the added responsibilities, has come an increase in recognition and prestige. Yet in shifting our emphasis to the mechanical functions of

nursing, the human being has become, in the process, a non-person and is treated as though he is devoid of feelings. This was confirmed as recently as 1976 in a research project based on the treatment, attitudes and interactions of hospital staff, terminally ill patients and their families as observed by R.W. Buckingham III. The participant observer became frustrated with the lack of meaningful contacts. Frequently staff, including doctors, went in and out without any recognition, by word or look, of the people in the room. Staff/patient contacts were mostly technical and usually brief. Interviews were rushed and restrictive, lengthy responses by the patient were tolerated reluctantly and impatience was evident if information given was not strictly related to staff concerns. Patients in general experienced monotony and loneliness.² The problem is compounded for the well person with a long-term disability. He is treated in the same sterile environment as the acutely ill but his plight is too often ignored in favor of more interesting cases.

In an extended care setting the nurse who tries to fill her time with mechanical duties is lost. She observes psychosocial concerns as a non-nursing function and resents the involvement. She wants to nurse, she says, but her actions belie her words. She busies herself with tasks such as

staffing, housekeeping, requisitioning and answering telephones. She "overnurses" the chart with meaningless entries but neglects the residents because she has not been adequately prepared to deal with emotional, social and rehabilitative problems. She neglects the resident because she doesn't know him as a person; she sees him only as a patient.

It is not that she has not been educated to be aware of the patient's psychosocial needs, but frequently when the new nursing graduate arrives in a working situation, she finds she is expected to do things as they have always been done and not as she was taught. She resigns herself to working under pressure and begins to forget her idealistic notions of caring for the whole person. When she is introduced to a people-oriented environment and stripped of many non-nursing functions, she lacks confidence and knowledge.

The nurse's social conscience has not been awakened sufficiently to the real needs of long-term institutionalized individuals. The nurse, however, is only part of the problem in our care for the elderly. Many times she knows what needs to be done and is committed in spirit but is unable to muster enough strength to overcome the inadequacies of the physical facility itself, and the resistance of the collective body of nurses who resist change.

A scientific approach

At the Juan de Fuca Hospitals, we are frequently asked, "How does one set up a therapeutic program for elders in an institutional setting?" As with any enterprise, we must start with a strong foundation and build an effective organization around it. The foundation stone is a central philosophy which expresses the collective values of professionals and non-professionals within the institution. Each plan, policy or procedure is passed through this mass of stated values, and beliefs, subjected to scrutiny of scientific background and eventually becomes filtered so that the action reflects the philosophy. For example, does one really have to restrict visiting hours? The answer is no, not if one believes in the therapeutic value of social interaction of friends and family.

Study and research are important tools in helping to formulate and test a philosophy, and devise new policies. As we begin to look at scientific research into human needs, we find a surprising amount of data which seriously question many traditional concepts of care for the elderly.

Perhaps we should look at human behavior in hospitals, where people are forced into congregate living with the loss of privacy because they are always in the presence of others. Vischer (1919) found prisoners in an environment of irritability and resentment, indulged in excessive criticism of others and boasting about themselves in an attempt to maintain their identity.³

We know the frustration and tension created from crowding. "Too many people must not be forced to interact together, regardless of whether the space provided is sufficient or not. We are not used to living in a crowd and to attempt to do so is unpleasant, even for a healthy person. It can so damage the mentally ill that they lose all hope of recovery".⁴ In light of this knowledge, we should critically view our large activity and dining areas.

Isolation not only leads to the destructive influences of boredom and monotony, but also has other far reaching effects. An experiment indicated that a condition of social isolation, in which pairs of men were isolated from society for ten days, led to a gradual increase in territorial behavior with respect to areas and objects in the environment and to a general pattern of social withdrawal.⁵ We therefore see the emotional stresses and eventual deterioration we subject people to when we isolate them in rooms that are too confining. Our buildings and policies must counteract these tendencies so that this territorial instinct will not be so intense as to create withdrawal and depression. Communal dining, indoor and outdoor recreation areas, community outings and functions all help to alleviate this difficult problem.

The results of these projects would also make one believe that our private and semi-private rooms for the fragile elders are perhaps more status symbols than therapeutic spaces. There is evidence that

groups of four to eight people are especially liable to form beneficial supportive and constructive relationships and that these can be enhanced by the presence of a nurse trained in group activity.⁶ Such activities would include reality orientation, remotivational therapy, sensory stimulation and other similar group work.

We must also try to understand the four personality variables so we can group residents to better advantage. For example, heterogenous affiliation groups had a relatively subdued, quiet and private relationship in which members bore one another in relative silence, at a distance, and from their own territories. Dominance incompatibility led to noisy, volatile, aggressive relationships. Dogmatism incompatibility yielded a socially active, non-territorial relationship while achievement incompatibility resulted in a more socially passive relationship. Further study of personalities showed those reflecting dominance and affiliation are oriented toward people while those with dogmatism and achievement were primarily oriented to ideas, tasks and things.⁷

We have all seen the trauma created for our elders upon admission when they have been separated from friends, relatives and their community. Complete mental deterioration can occur. Visualize the anguish we create when we separate devoted couples who don't fit the same criteria of need, for example, one in personal care and the other in intermediate care. They are often separated for life, each

deteriorating due to the pain of mourning and longing.

Experience shows us that moving an old person, even from one room to another, can be so stress-inducing, which can lead to confusion. Research at Parkwood Hospital in London, Ontario, found evidence that relocation, even within the facilities, can be hazardous. They found "intra-institutional transfers can result in perceptible changes in the patients' living pattern that can influence survival and overall physical and mental level of functioning."⁸ With this knowledge in mind we must be very cautious when we plan a disrupting move for residents. Careful, thoughtful deliberation and preparation to avoid serious trauma is most essential.

Our physical facilities must be designed to eliminate all barriers to independence. Positive attitudes are important in good planning, so that all areas are built to alleviate deterioration and to ease the workload. I have seen a modern senior citizens' home where the windows were so low it was impossible for an average-sized person to look out unless he was sitting down or standing on tiptoes. Naturally, this creates immobility by making sitters out of well people. In the face of such planning, how then can we justify spending money on expensive and unnecessary exercise equipment.

There are those who say the quality of care I am advocating will cost too much money. But it is clear that due to poor planning we waste a great deal of money



trying to cope with deterioration created by a "criterion that is not only inappropriate, grossly inefficient, and costly but harmful as well."⁹

A positive philosophy, scientific evidence, imaginative planning of the environment — these are all necessary for the rehabilitation of the aged. But there is one modification, the least expensive of all, that assumes an importance above the others because its absence is felt most acutely by the residents. That ingredient is loving, expressed through therapeutic attitudes, such as listening, smiling, talking and touching.

How can we as planners, build environments where these attitudes flourish? At the Juan de Fuca Hospitals, we have tried to accomplish this by developing our program around a commitment to the dignity and self-worth of each individual. To do this we felt we had to change the way staff related to each other before we could change significantly the way they related to the residents. Perhaps it is time now to look at this process as it evolved in our hospital.

Humanizing the work space

When we started our program in 1967, we had 95 ladies whose average age was 85. They suffered mainly from severe mental and physical deterioration because they had been recipients of custodial care. Although we started with acute care concepts, we soon recognized our shortcomings. We wanted to create a warm environment where the ladies would respond to expectations of "wellness," and where both residents and staff would be able to move towards self-actualization. In short, what we wanted to create for our residents was not a hospital, but a home.

As we grew, our style of management changed because the traditional structure did not complement our philosophy. The nurse in

charge spent a great deal of time in duties relating to staffing and did not really have time for the nursing process. We therefore established a support service headed by a unit coordinator (manager), and in this way, relieved our nurses of duties related to staffing and most of their non-professional and administrative duties.

To promote professional self-direction we tried to eliminate the master-servant, superior-subordinate relationship, which fosters passive dependency on the part of the worker. In our organization, the administrator has direct control and maintains a focal point in an informal manner. Communications between staff in the various disciplines generally remain open in an endeavor to integrate all services within the total program. Hence, straight line communication is not always practiced; staff have the freedom to communicate horizontally or diagonally in order to gather data and communicate more effectively. Those who lack maturity can maintain the security of the line organization until they feel comfortable and confident within our concept.

Once the nurse gains confidence, her leadership and innovative abilities come to the fore. The need for supervision is reduced because the person in the lower ranks is ready to assume responsibility in decision-making, allowing her superior to become a resource person, colleague and evaluator. Such an atmosphere contributes to personal growth and in turn to a striving for ever higher standards in the hospital.

Participatory management, a theory that is often only given lip service, is practiced informally, with views and opinions being solicited from all staff. Our team approach includes all professional and non-professional disciplines. For example, our physiotherapist does not practice in isolation, keeping other disciplines in

ignorance as to the intended outcome. She is on the floor teaching and demonstrating to staff in order that restorative techniques can be maintained 24 hours a day, seven days a week. Some days our housekeeper can be seen leading a recreational singsong. In this way, all disciplines tend to blur into each other's roles, each becoming a generalist with this increased knowledge. We agree with Argyris¹⁰... that specialization breaks the work down into small components resulting in shallower interests and a lack of self-fulfillment and self-importance. By becoming generalists, greater motivation is again created and staff identify with the goals of administration — namely, improved resident care.

We try to normalize the environment as much as possible in an attempt to create a homelike atmosphere. To achieve this, as well as to help overcome compartmentalization in our facilities, uniforms have been dispensed with in all departments. All staff present themselves in gay "civies." Pride in self is encouraged. Residents are dressed in becoming attire and expected to play the well role. Besides reducing the patient-nurse relationship which leads to dependency, informal dress helps overcome levels of status and contributes to a greater team effort.

Since the limits to our concept of restorative care depend so much on the creativity and innovative ability of the staff, the time we have spent considering management and how best to encourage self-direction and self-fulfillment has reaped rewards for staff and residents alike. In such an environment, dependency in any form is discouraged. For the residents, this is a welcome change from custodial care and they respond accordingly. We assume all have the potential for some recovery and we build on our strengths. Our gains vary from a sweet smile to independence and we delight in both.

Self-actualization

We have opened our doors and welcome all who come. We encourage family, friends, children, even their pets, to visit whenever possible, and make every attempt to include them in our activities so that the environment becomes part of their life, too. Spouses are especially welcome, and the coffee pot is always on. When a special event like an anniversary occurs, we serve the couple dinner at a secluded table. Whenever possible, we encourage the husbands to aid us in our therapy. Once we admitted a 65-year-old lady, a graduate nurse, who showed severe regression. Her husband was very devoted and naturally felt depressed over his wife's condition. We encouraged him to come often and take his wife out. This surprised him because this had not been the case at the former agency. We explained reality orientation to him and requested that he assist us. He was delighted. He would take his wife out car riding, tell her the time, date and discuss the



weather. He would explain where they were going and stop along the way to pick flowers. He read the headlines to her and discussed current events. He told me he had even started singing. In a few weeks this man, who had been so hopeless and depressed, walked with a spring in his step and happiness in his eyes. Before he became involved with his wife's therapy this man told me that he had lost the ability to talk to his wife.¹¹

Community involvement is used as much as possible to aid us in social therapy. Volunteers are indispensable and with their help we have carried out many different programs. We bring in hairdressers to introduce the latest styles and trends as a way of encouraging the ladies to take pride in their appearance. It is all in fun and even the husbands join in, much to the amusement of all concerned. We take residents out for tourist outings. Every year we stage the Priory Stampede for which performing horses are brought right onto the grounds. For this event, staff wear western garb to add to the atmosphere. We also have yearly mutt shows where children from miles around come to show off their pets. The ladies are used as judges and they dole out the prizes. Suddenly they are useful, they can still bring joy and pleasure to someone.

The ladies also have their own kitchenette where they can make sandwiches and cookies for festive occasions. They participate in Christmas concerts and send favors to children in hospital. We have wine and cheese parties, and gambling at the Casino. We have even tried our hand at making our own wine.

The "Best Band in the Land", after many community appearances, is to participate in the Lions Club telethon. The 103-year-old conductor is always on the beat with her baton and the band brings out some unexpected skills. Residents can be seen having breakfast at the Pancake House, enjoying MacDonald hamburgers by the sea on a winter's picnic or dressed to the nines for dinner at an elite restaurant. Being in wheelchairs is incidental. Students come into the facilities and residents "go back to school" to share skills in home economics.

The community could be used even more than it is but there is always the difficulty of transportation and personnel required to transfer handicapped to and from wheelchairs. Yet with imaginative planning and a change in attitudes we could alter our facilities to encourage more community involvement. Perhaps we could attach a large auditorium to long-term facilities and encourage community participation. Allow the community ladies to have their working sessions, bazaars and bingo parties. Let the children play games and put on concerts. Have a stage for entertainment and movies. Then all we would need to do would be to wheel our residents in and the community would provide the stimulation and motivation that is so beneficial. Some elderly do not

have the strength, nor can they tolerate the excitement and confusion of an unfamiliar outing, but functions at home would not create this apprehension. The community would help to meet the psychosocial needs we have such difficulty coming to grips with. The auditorium could also be used as a day care centre and gym for the aged in the neighborhood, creating more stimulation for all. The strongest members could help the weaker ones, and this would give them a purpose in life. The aged utilizing the day care center would be in familiar surroundings and when their time came for admission the break from their home environment would be less traumatic. No doubt the time of admission would be delayed because of the effects of active involvement in the center.

Philosophies and priorities

There is no limit to the possibilities if we are willing to change our roles and attitudes towards the aged, embrace a concept of quality care for the total person, use our imaginations and liberate the environment. This is not an abstract concept but a process that each of us can begin now.

Critically evaluate your facilities and beliefs. Have you grown so accustomed to deficiencies that you do not see anything wrong with using catheters for staff convenience, using syringes to feed the slow eating residents, or seeing your residents sit by the hour in idle boredom because you do not encourage volunteers or visitors? Do you refuse to admit couples or permit them to share a double bed if so desired? What was once considered good and basic care needs to be questioned. If it is no longer appropriate or effective, we must reject it. Professional roles and skills that continue to give the same care to all are not listening to the pleading of a unique person. Pathology can no longer be a priority. Preventative and restorative techniques must be applied to social, psychological, emotional and spiritual distress just as avidly.

The nurse must be as concerned with the enrichment of human life as she is with saving it. She must become convinced that she has a role to play in providing a beneficial social environment in the extended care setting. She must open the door — welcome visitors, encourage volunteers and participation within the community. The community will help her restore the resident to social health, and the resident will lose her symptoms one by one. Once we truly understand and become convinced of this, we can intelligently approach our long-term residents and involve them in living experiences rather than dying ones.

A vague attachment is not enough. We must become convinced and committed activists. We must make quality care for the aged a reality. We must reflect our knowledge to add a brighter dimension to the lives of our residents and the staff with whom we work. If we fail, in a few years we will have the opportunity of reaping our own harvest. ☘



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Communicating with the hard-of-hearing



When was the last time you heard a nurse hollering at a patient in an obviously futile attempt to get her message across? How did you react, and what expressions did you notice on others who could hear her?

Chances are that the nurse was shouting because the patient had trouble hearing her, that she was trying to be helpful. But volume isn't always the answer. Author Christine McNamee not only tells us why, but lets us know what we can do to communicate effectively with those who are hard of hearing.

Communicating

Christine McNamee

Perhaps the most distinctively human of all handicaps is impairment of the capacity to comprehend language. Breakdown in an individual's ability to communicate with others through the use of language has many effects. It is the most clearly identifiable factor complicating and deepening maladjustment in the mentally and emotionally disturbed. It often accompanies the normal aging process.

Studies have shown that sensory loss ranks second as a cause of low morale among the elderly.¹ Some theorists believe that delusions of persecution as well as hallucinations in the elderly stem directly from sensory deprivation. If you cannot hear, it is difficult to understand with any accuracy what is going on.

One out of every four people over the age of 65 is affected to some degree by hearing loss. It may be caused by a decrease in overall sensitivity to sound, or by selective loss of hearing for higher pitches. The former is due to mechanical problems caused by ossification of the articulating bones of the inner ear, and can be corrected by surgery, use of a hearing aid, or both. The latter is due to neurological changes, and is not reversible.

Burnside suggests an effective exercise for trying to understand the handicap brought about by hearing loss.² Adjust the car radio volume to slightly less than normal (simulating overall loss of sensitivity). Then, turn the tone adjustment to full base (simulating selective loss of high pitches). Although you will still be able to hear, you will probably have to strain in order to understand what is being said.

Although certain hearing problems can be improved through the use of a hearing aid, this is not true of all of them. The cause of hearing loss must be determined by a certified hearing specialist, and if a prosthesis is indicated, it should be prescribed and fitted by this specialist, an individual who is not in the business of selling aids. Hundreds of elderly people are bilked by unscrupulous door-to-door peddlers who sell them hearing aids that are useless for their type of hearing loss. Burnside cites an example of one elderly woman who died leaving 36 hearing aids in her drawer.³

Hearing loss— what it means

In addition to a fundamental knowledge of anatomy, physiology, neurology, and the pathology of hearing, we as nurses need to have a basic understanding of what hearing loss means to the individual in order to communicate effectively with him. In order to understand, we must look at the physiological, psychological and sociological effects of hearing loss.

Physiological effects may include dizziness, poor balance, or both, if there is middle ear involvement. The hard-of-hearing may suffer from fatigue because they have to concentrate harder in order to hear. Head noises are common, and these disturb rest and may result in tension and irritability. Finally, adaptive posturing such as squinting, grimacing, frowning and head tilting can give the person who is hard of hearing a rather odd appearance, so that people may respond to him in a negative way.

To recognize the psychological effects of hearing loss, we need only think for a moment. Hearing is something we all tend to take for granted and its loss is frightening and demoralizing. Hesitancy and fear of involvement in social activities are very common among the hard-of-hearing. The individual may feel that he is incapable of participating; he may fear rejection.

Sensory deprivation may also result in emotional flatness, passivity, dependency and boredom. Often he will have impaired interpersonal relationships, so that his needs for affection and a sense of belonging are not fulfilled.

Someone who is hard of hearing may develop rigid defenses, so that he will exhibit what seems to be an unreasonable fear of physical or psychological intrusion. It is also very easy for him to imagine that others are talking about him, almost to the point of a mild paranoia.

Our society places a high value on wholeness and functionality. For this reason deafness can result in social isolation; the individual who is hard of hearing may be forced into withdrawal. He may be incorrectly labelled apathetic, goal-less, uninvolved, unmotivated, senile, or even schizoid. He may suffer from loss of status because it is easier to exclude him from activities and decision-making as he is an *inconvenience*. His self respect may suffer when people regard him as *simple* because of his lack of comprehension.

Sensitive communication

Loss of hearing can have profound effects on an individual. If we understand these effects, we can also see how important it is to maintain effective communication with those who are hard-of-hearing. Awareness of the following points may help the quality of communication and the relationship that develops between the nurse and the patient who is hard of hearing.

1. The responsibility for understanding conversation does not rest entirely with the person who is hard of hearing. In the hospital situation, it is partly the nurse's responsibility. This has important implications with regard to safety considerations, especially in such matters as preoperative instruction, where the patient's safety depends on his comprehension. In these cases, return demonstrations and verbal feedback can serve as checks of comprehension.

comprehension.

2. Reassurance is very important for the patient since he may misinterpret sounds or misunderstand communications. Body language, always of great importance, assumes even greater significance in any interaction with the hard of hearing. This individual has learned to rely on his eyes to help him hear, much as someone who is blind depends on heightened auditory acuity. The nurse's ability to communicate warmth and understanding through body language is especially important in establishing a trusting relationship with the patient.

3. Get the patient's attention before you speak, by calling his name or gently touching his arm. Then he will be ready to concentrate on your words. He may not have heard your approach, especially in a hospital setting, where nurses wear soft-soled shoes.

4. Remember that medications may affect his ability to pay attention.

5. Most hearing problems are not improved by loudness — it doesn't help to shout at someone wearing a hearing aid. Shouting can distress the patient unnecessarily because it means loss of privacy. It may also offend the sensibilities of

nearby patients, particularly if what you are shouting is of a personal nature. It may also disturb their rest.

6. Speak clearly, and not too quickly.

7. Face the person directly, and keep your hands away from your mouth when you're talking. Many of those who are hard of hearing depend on lip-reading to augment their hearing capacity. For this reason, it is also wise to consider lighting when conversing with such a patient: make sure it is sufficient to allow him to see your lip movements clearly.

Attempts at conversing with the patient when his back is turned to you, as during back care or bedmaking, will probably result in anxiety and frustration for him. He may not feel free to mention his discomfort to you, because he recognizes that you are trying to be pleasant.

8. Know which side is affected. Not all patients have bilateral hearing loss; even if they do, the degree of hearing loss may differ. If this is the case, attempts to converse with the patient when his good ear is turned into the pillow will likely be unsatisfactory. Always stand on the side of the bed corresponding to his good ear, to take advantage of the unique funnel-like anatomy of the outer ear.

9. A foreign accent is a problem for the hearing impaired, so if you have an accent, be prepared to use a pen and paper. Remember too that for foreign-born patients for whom English is a second language, we are the ones who are difficult to understand.

10. When you are asked to repeat a sentence a couple of times, find a different way of saying the same thing, rather than repeating your original words over and over. It may be a particular syllable or tone that is causing the difficulty.

11. Never use the patient's deafness as an excuse to talk over him to another nurse, doctor or visitors. Remember the tendency of the hard-of-hearing to imagine that others are talking about him. And think of how frustrating it is to be excluded in this way.

12. Background noises such as traffic sounds, television, and radios, make listening and hearing more difficult.

13. Gestures can be very useful if they enhance what you have to say. Aimless gestures only serve to distract the patient.

14. Accusations that the hard-of-hearing person "hears only what he wants" are unjust. In order to pick up information, he must concentrate harder and he tires easily. So, in actuality, he does hear "only what he can." When he is tired or distracted or ill, he is less able to hear and to understand. His ability to hear changes with each situation and with each speaker.

15. Impatience with his listening behavior will not help, but will only cause him to become tense and hear less. This applies also if the patient is made to feel that you are rushed. The more relaxed and accepted the hard-of-hearing person feels, the better he can communicate.

You will notice that the points I have mentioned imply sensitivity. If you understand the physiological, psychological and sociological effects of hearing loss, and recognize the hearing impaired individual as an individual with communication needs, you will be sensitive. Such sensitivity can only contribute to a mutually satisfying nurse-client relationship. 4



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Christine is presently a full time student at the University of Victoria, Victoria, B.C. completing the requirements for a B.S.N. degree. The focus of the course is on gerontology, and Christine says this article "is a result of my increasing interest in this rewarding field."

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ONE DAY THE DOOR CLOSES

How does it feel to give up your home in the community and move into an institution for the aged? What prompts you to take that final step? What do you miss the most, afterwards?

Janet McIvor
Lois Sorgen

Understanding how a person feels about a milestone as significant as entering a home for the aged is important — so important that we, as nurses who care for the elderly, decided to conduct our own investigation into the reactions of a group of residents in the institution where one of us was working at the time. A review of the literature had indicated a surprising scarcity of documentation concerning the perceptions, thoughts and feelings of individuals who are admitted to these institutions. This fact, coupled with our interest in the psychosocial needs of the elderly, prompted us to embark on our project.

Our subjects were 27 residents (24 women and three men) of a newly opened home for the aged, located in Saskatoon, Saskatchewan. They ranged in age from 73 to 94 years of age (average age 83.5 years). All but one were considered as either Level I or Level II patients under the provincial regulations of the Saskatchewan Departments of Public Health and Social Welfare. This meant that they required either supervisory care or limited personal or nursing care, rather than intensive personal or nursing care. None of them had either a functional or organic psychosis.

Of the 27 patients, 22 were widowed; three had never married; one was separated and one was still married and his spouse was also a resident of the lodge but on a different floor. At the time we conducted the interviews, these men and women had been living in the lodge for a period of from seven to 47 days. The average stay to date was 36 days.

Twenty of the residents had moved from their own apartments; two had been in their own detached homes; four had been living with other family members and one was living in a private nursing home.

The setting

The home into which our subjects had moved is operated by a non-profit organization. It accommodates residents from all three levels recognized by the provincial regulations governing care for the aged (See figure one).

Level III patients live on the first floor of the lodge, while the second floor is reserved for Levels I and II residents. All levels are integrated for meals and activities such as carpet bowling, bingo, cards, sing-songs, church etc.

Each resident has a private room which is attached to the adjoining room by a bathroom. Individuals are allowed to bring their personal television, or stereos and lounging chair. If desired, carpets can be laid and pictures hung on the walls. There is also a kitchenette at the resident's disposal on the second floor for making light snacks, tea, coffee etc.

The staff includes registered nurses and geriatric aides who have had a four-to eight-week training period consisting of theoretical and ward work prior to being hired on a permanent full-time basis.

The interviews

As a preliminary step, we prepared a list of 14 questions related to the area we planned to investigate (See figure two). Then we selected a time period of one week and arranged to see each of the 27 respondents individually during this period. During the interviews, we followed the same procedure with each subject, asking each respondent the same questions and encouraging elaboration on all points. As a staff member, one of us was known to the residents while the other was not but this seemed to make little, if any, difference. This might have been because we wore street clothes rather than

Figure one

Level I

Supervisory care. Essentially independent, but may need some guidance or supervision in the activities of daily living.*

Level II

Limited personal care. Supervision and assistance may be needed with personal hygiene and grooming. Safely ambulant with or without mechanical aids or independent at the wheelchair level. Usually continent and able to feed self.

Level III

Intensive personal or nursing care. All degrees of supervision and assistance may be needed in the activities of daily living.

* Activities of daily living refer to such things as eating, brushing the teeth, combing the hair, walking, urinary and bowel elimination — the facets of daily living that capable persons do every day.

Levels of care for the Province of Saskatchewan Summary, Province of Saskatchewan, May, 1973.



Figure two

THE INTERVIEW GUIDE

1. Where did you live before you came here?
2. Were you getting any help from any persons or organization in the community?
3. What kind of help would you have needed to stay in your own home?
4. Did you decide to move into Stensrud Lodge? How did you come to that decision?
What were your feelings at that time?
5. If you didn't decide, who did? How did you feel about that?
6. What were your expectations about coming here? Did you have any fears or concerns?
Did they happen?
7. What kinds of things went through your mind while waiting to come here?
8. What was the hardest for you in coming? The easiest?
9. What (if anything) do you think would help make such a move easier? Could the nurses help? How?
10. How did you feel your first day(s) here?
11. How do you feel about being here now?
12. What do you miss the most?
13. What is the best part of being here?
14. Is there anything else that you would like to add about your move?

Our observations

More than half of the residents had not made the decision to move on their own initiative. Three had been told by their physician that they were not to live alone any longer; 12 had been similarly advised by family members; a social worker had advised one person; and two individuals did not know who had made the decision. The remaining residents had made their own decision, some wishing to be in a facility where help would be available should they need it and some stating that they did not want to be a "burden" to their families. Two stated they wanted "to get away from being alone."

Four people had been receiving assistance from community agencies. This included catheter changes, foot care, vacuuming and hanging out laundry. Only one of the 27 individuals could identify or name specific assistance they would have liked or needed in order to remain in their homes. This was a gentleman who

would have like to have had meals prepared for him.

Generally, those who had made their own decision to move stated that they felt good about it and had few worries or concerns. On the other hand, those who had not, stated that they had felt despondent or had given up caring and had come to accept the fact that they would be moving into a home which was where they were going to be. This is what some of them had to say about the move:

• "I have only one chair left, but I don't care, this is the last lap for me."

- "I'm getting so tired, I don't care."
- "I didn't want to come but the doctor said I had to — I felt just terrible."
- "I wondered if I'd like it and worried that if I didn't I wouldn't know what to do."
- "I tried to make myself think this was the best thing for me."
- "I worried myself sick wondering if I'd made the right decision."
- "The arrangements were made and I had almost no time to get ready."
- "This is my last resting place because I'll never move again."

In spite of the fact that most of our



respondents had a general idea of what to expect (e.g. private rooms, meals prepared), some were surprised that they still had to purchase their own medications and make their own beds. The married gentleman expected that his wife would be in the next room. One person was "appalled" that it was not more like a hospital with posted and enforced rules and regulations, while another expected the lodge to be a retirement home rather than a place where "there are so many crippled and dying on their feet." In general, however, there seemed to be a general feeling of relief and comfort that they would be taken care of in the event they became sick or got "worse."

Only one individual was making plans to leave. Two others were considering it: one who felt the other residents were less well physically and less independent than he, and another who was awaiting a decision on her wish to have a rug installed in her room. This lady had made her own decision to move and was in no way reluctant to approach administration with her concerns. Unlike most of the others, she spoke with a great deal of conviction and authority.

Almost all of the 27 individuals interviewed felt that breaking up their homes and parting with their possessions was the hardest part of moving. Three people specifically mentioned the bed they had shared with their spouse, and one lady who had lived alone felt the greatest loss in having her cat "put to sleep" and her dog placed in a kennel. This was an individual who, at 87, planned on returning to her home in the Spring. Her home, incidentally, is not in the city and lacks the modern conveniences of indoor plumbing and central heating. This lady also commented on how she missed the companionship of younger people, particularly the adolescents in her rural neighborhood.

The first day

No one felt that the move had been easy or that there was one thing that had been easiest. Their answers to the question on how they had felt the first day, indicated that nearly all had been lonely and upset. For example:

- "The first day I felt like I was in a prison in this little room with the doors shut."
- "It was terrible — I missed my friends."
- "I was lonely and scared I'd fall out of this narrow bed."
- "It was lonely and frightening without my own things."
- "I cried and cried."
- "I tried to console myself."
- "It was all so strange; I cried."
- "Everything upset me."

Three people said they had not felt well physically during their first few days in the lodge and had slept most of the time; only two people of the 27 said they had been pleased and had felt good about being there.

When asked if and how nurses could assist them to feel more comfortable during their first day, only one person suggested that having someone to talk to would be helpful. The other 26 people felt in one way or another, that it was a "personal" experience which everyone had to deal with in their own way.

Adjustment

What the residents missed most at the time of the interviews varied a great deal. The following were some of the things mentioned: "having people stay overnight," "the trees and the live stock," "bridge parties," "neighbors and friends," "gardening, cooking and cleaning," "everything," "my wife more than anything."

Similarly, the residents saw their present situation in different ways. Six individuals

stated they didn't feel any differently than they had on their first day. It seemed, however, that these individuals had, to some degree, resigned themselves to being in their last home, although one stated "This is no home!" Two described it as "their last resting place" and two individuals said that they prayed to die. Comments at the opposite extreme were "I couldn't be better" and "I'm comfortable and happy." These were made by individuals who had made their own decision to move into the lodge.

The greatest number of residents saw the availability of nursing and medical assistance as the best part of being in the lodge. All were pleased with the care they received, although one person commented that she found it difficult when people tried to help her when she didn't need it or want it. This person was 94, the oldest person interviewed.

Summation

During these interviews the researchers noted a great willingness to talk and a high degree of openness on the part of these men and women. A few became tearful and visibly anxious, stating that it was difficult for them to talk about it. Nearly all of them expressed gratitude and appreciation for the opportunity to talk about their experiences, and in many cases it was difficult to terminate the interview. It was interesting also to learn that many of them had been eagerly awaiting their turn after the first residents to be interviewed had told the others about the project.

It appears that an individual's admission to a nursing home is a very emotional experience and one which requires further study and research. Because of the subjective and limited nature of our project, it is not possible to make sweeping



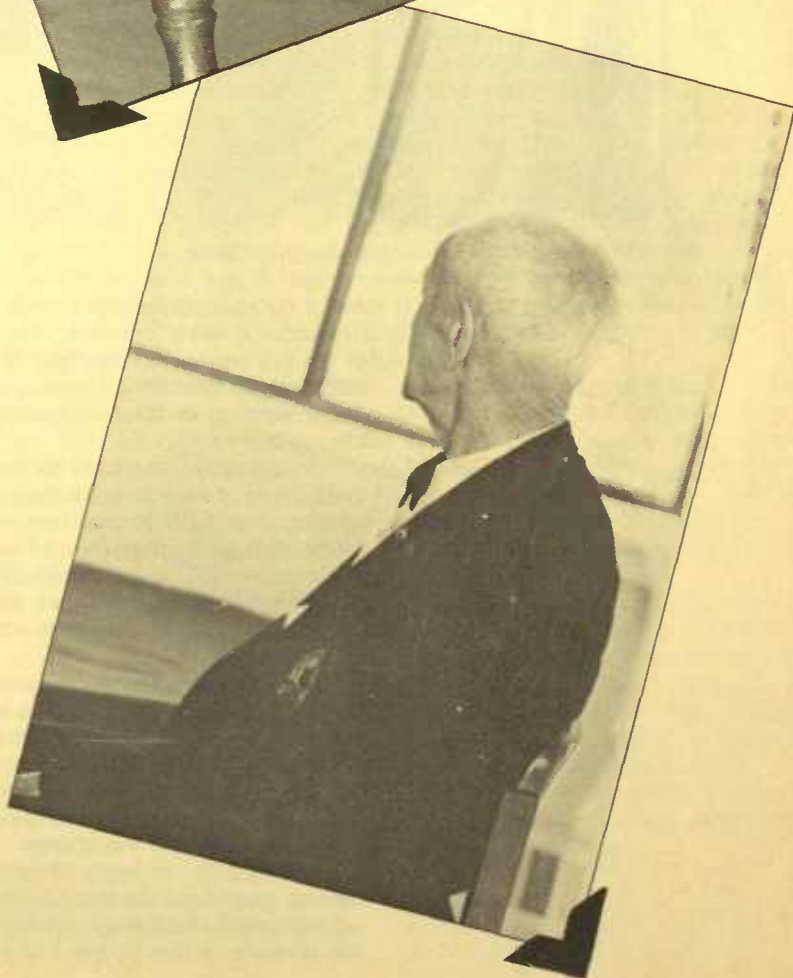
generalizations nor to draw firm conclusions on the basis of our observations.

We are left, however, with the conviction — if not the proof — that the act of leaving their own homes and entering an institutional setting arouses feelings of powerlessness and resignation among many older people and that insecurity and loneliness are the two themes which run through their descriptions of this significant event in their lives.

At the very least, nurses in the community or in institutions, must be alert and able to respond to the thoughts and feelings of these individuals who are taking what can be, and often is, a very difficult step. 4

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Legal consent and the nurse



Photo courtesy Vancouver General Hospital

Corinne L. Sklar

Ask a nurse what springs to mind when you mention the word "consent." Nine times out of ten the answer will be "the document the patient signs permitting the performance of a major surgical or medical procedure during hospitalization."

In actuality, however, consent is involved each time a nurse bathes a patient, bandages or catheterizes him, administers medication, turns or examines him. The list is endless because it encompasses all of the multitude of nursing activities that involve physical touching of a patient and ministering to his needs.

Nursing liability for lack of consent could arise anytime a nurse compels a patient to comply with a physician's orders. For example, if a patient refuses to take the medication that has been ordered for him, nurses may hold the protesting patient down and administer the medication intramuscularly.¹ In such situations, these nurses must balance the patient's right of refusal against their responsibility to carry out the doctor's orders in the interests of the

patient's health. To do this, they must understand the legal consequences that can follow from carrying out orders forcibly or in the face of express refusal.

Nurses are no longer the "handmaidens" of another health profession. As responsible, independent practitioners they must be well informed, highly skilled and willing to question orders rather than follow them blindly. Today's nurse faces a myriad of complex technical equipment and procedures. Her patients are also better informed, more questioning in their attitudes and more vocal about patient rights.

The continuing explosion of scientific knowledge is a force the nurse must reckon with in fulfilling the goal of giving quality nursing care. If she remains unapprised of her rights and responsibilities in law, she does a disservice to herself, her colleagues, her employer and, most of all, her patients. It is the purpose of this article to assist in explaining the law of consent and its applicability to nursing practice.

The Law

Battery

In both nursing and medicine, touching of the patient's person is essential and basic to practice. In law, intentional touching of a person without consent amounts to the tort (civil wrong) of battery. The law considers such a wrong compensable in money damages. It is important to know that even if no harm is occasioned, liability for battery still arises.² The degree of harm resulting affects the amount of money damages recoverable.

Battery, so designated in law, is referred to in colloquial terms as assault. In legal terms, assault refers to "the intentional creation in another person of an apprehension of imminent, harmful or offensive contact."³ It is the individual's right to freedom from bodily invasion and the preservation of individual dignity and integrity that the law is protecting here.

Protection of the Individual

"Every human being of adult years and sound mind has a right to determine what shall be done with his body ..."⁴

These words of Mr. Justice Cardozo reflect the law's cardinal principle of the inviolability of the human body and the right of the individual to control invasions of his bodily integrity. There are two elements that eliminate the wrongful aspects of touching: consent and lawful justification. These elements render the ministrations of nurses and physicians lawful. The right of the individual to control invasions of his person is subordinate to another legally protected societal value: the value of human life. It is the protection of this latter value that permits nurses and doctors to act without the patient's consent in an emergency situation to preserve life or health.⁵ In fact, in a case like this the law often recognizes the patient's implied consent.

Negligence

Where a legal action arises based on absence of consent, alternative legal approaches may be taken. The complaint may be framed either in terms of the wrong of battery or in terms of negligence. Negligence refers to acting below the professional standard of care the nurse owes to her patient. However, the wrong of battery may be committed by a nurse even when she is exercising the highest quality of skill and care, for the criterion in battery is lack of consent and not want of skill.

Standard of Care

In *Lamphier v Phillips*, Chief Justice Tindall stated, "Every person who enters a learned profession undertakes to bring to the exercise of it a reasonable degree of skill and care ..."⁶

Willig describes the standard of care in this way:

"A nurse must discharge her responsibility to the public according to the standards, knowledge and procedure established at the time and place she is practicing. This responsibility is further determined by the nurse's training and experience and licensure all of which are reflected in the title accorded her and the status she receives in practice."⁷

In *Dowey v Rothwell*,⁸ the court held that a nurse, being a professional person with special training and skill, is bound to exercise the degree of skill and care that can be expected of any reasonably prudent nurse of the same experience and standing. In that case, the nurse's negligence occurred when she left an epileptic patient who was complaining of aura symptoms unattended on an examination table. During the seizure that followed, the patient fell off the table and broke her arm. The nurse was found liable.

Nurses should realize, however, that the law does not demand perfection of them. Neither physicians nor nurses are considered legally responsible for mere errors in judgment because "an error in judgment has long been distinguished from an act of unskillfulness or carelessness or due to lack of knowledge."⁹

Elements of Consent

The law clearly states "there is no wrong done to one who consents — violenti non fit injuria."¹⁰ Consent may be express i.e. declared in words or writing (consent form) or implied i.e. by conduct (holding out one's bare arm for vaccination).¹¹ Generally, nurses can rely on the patient's implied consent to protect them in giving care. Clearly, it would be ridiculous if for each ministration e.g. the taking of temperature, a formal signed consent were required. The implied consent of an open mouth suffices. However, it is important to note that admission to hospital does NOT confer a blanket consent for all acts done to the patient during the hospitalization. The patient's rights do not evaporate when he dons a hospital gown.

The constituent elements of consent must be present to answer the wrong of battery. The elements or criteria of a valid consent are

- capacity,
- voluntariness,
- consent to act performed,
- informed consent.

Remember that where there is an emergency or other life/health threatening situation, the absence of one or more of these elements does not necessarily amount to a lack of consent.

1. Capacity

The patient must be legally capable of consenting and therefore age is a relevant factor. The patient must be old enough to appreciate the nature of the treatment and be able to come to a reasoned decision whether to accept or reject it. Hence the right to give consent is reserved to adults, persons traditionally attaining such status at age twenty-one, although this is altered by legislation in some jurisdictions (Age of Majority Statutes). While the legal implications for the nurse in caring for minors are beyond the scope of this article, nevertheless, nurses should be aware that minors generally do lack capacity to consent in their own behalf. Parental or guardian consent is required.

Legislative exceptions do exist in some provinces. In Ontario, the *Public Hospitals Act*, in requiring that a signed consent precede any surgical operation, states that a sixteen-year-old may give consent for a surgical operation.¹² In Quebec, a minor of fourteen may give consent and parents need be informed only if the minor is hospitalized longer than twelve hours or if treatment is prolonged.¹³

The patient's *mental status* is also relevant to capacity, for consent is based on the patient's having made an informed judgment. The capacity to consent of a patient who is sedated, febrile, severely depressed or wracked with pain may be questioned and would depend on the facts in the circumstances.

Similarly, the level of consciousness of the patient would be relevant. In dealing with an unconscious patient, legal consent would likely be implied for nursing procedures based on the pertinent life/health threatening circumstances. The consent of psychiatric patients raises further issues which extend beyond the scope of this article. Factors here would likely include sedation, reality testing and level of functioning.



2. Voluntariness

The patient must give consent *voluntarily* without fraud, misrepresentation, force or duress. A physician who performed an abortion on the pretext of treating a uterine abscess was held liable. The misrepresentation vitiated or nullified the consent obtained.¹⁴

3. Consent to Act Performed

The consent need not be specific in every detail but it cannot be so general as to be meaningless. *The consent must conform generally to the act performed.* If the act performed is different from or exceeds that for which consent was given in the absence of any lawful justification (emergency, health threatening situation), then the consent will be vitiated (or invalidated). For example, in each of the three cases cited below, the previously given consent of the patient was invalidated because the operation that was actually performed either was different from or went beyond the procedure to which the patient had consented.

Act Differs:

- Consent to surgery on right ear. Operation performed on the left ear.¹⁵

Act Exceeds:

- Physician amputated hand against patient's express refusal.¹⁶
 - During Caesarian section, physician also tied off patient's Fallopian tubes.¹⁷
- In yet another case, when a physician removed a diseased testicle during a hernia repair, this act was considered to have been justified because of the urgency of the condition and the advanced age of the patient.¹⁸

4. Informed Consent

Informed consent means disclosing to the patient *sufficient information*, in language he can understand, regarding the proposed treatment. Then the patient, armed with knowledge of the hazards, risks, benefits and alternatives, can make a reasoned decision whether to accept or reject treatment.

The degree of disclosure is a thorny problem of judgment for physicians and nurses.

The physician is duty-bound to disclose all material facts to the patient. He is also duty-bound to protect his patient from undue alarm. How much information should nurses and doctors disclose? Is reliance on professional judgment enough? Is the nurse negligent for disclosing more to the patient than the physician intended?

The doctrine of informed consent was recently canvassed in the case of *Kelly v Hazlett*.¹⁹ Mr. Justice Morden of the Ontario High Court stated that the duty to disclose is one of medical (and likely nursing) judgment rather than one of absolute content. If the patient is told honestly regarding the necessary character and importance of the operation, its probable consequences, the degree of success expected, and alternative measures, if any, then that is sufficient. The patient then has enough information on which to decide. The duty extends neither to warning the patient of all dangers incident to the operation nor to details calculated to frighten or distress the patient.²⁰

Nursing implications

According to certain hospital laws and generally in practice, consent in writing must be obtained prior to surgery. The responsibility for this lies squarely with the medical profession. However, physicians often delegate the task of obtaining the patient's signature to the nurse. It remains a nursing responsibility to ensure that the signed consent form is on the chart before the patient leaves for surgery. As well, operating room nurses must ensure that the consent form has been signed.²¹

It is imperative that nurses understand that a signed consent form does not automatically absolve nurses, doctors and hospitals of liability. Such a form has only evidentiary value; the circumstances of the case determine the validity of the consent. That is why nurses need to be aware of the four elements that make up a valid consent: capacity, voluntariness, consent to act performed, and informed consent. The nurse has a duty to patients, physicians and the hospital to question or report circumstances which lead her to believe that one or more of these criteria are not being met and that the consent might, therefore, be invalid.

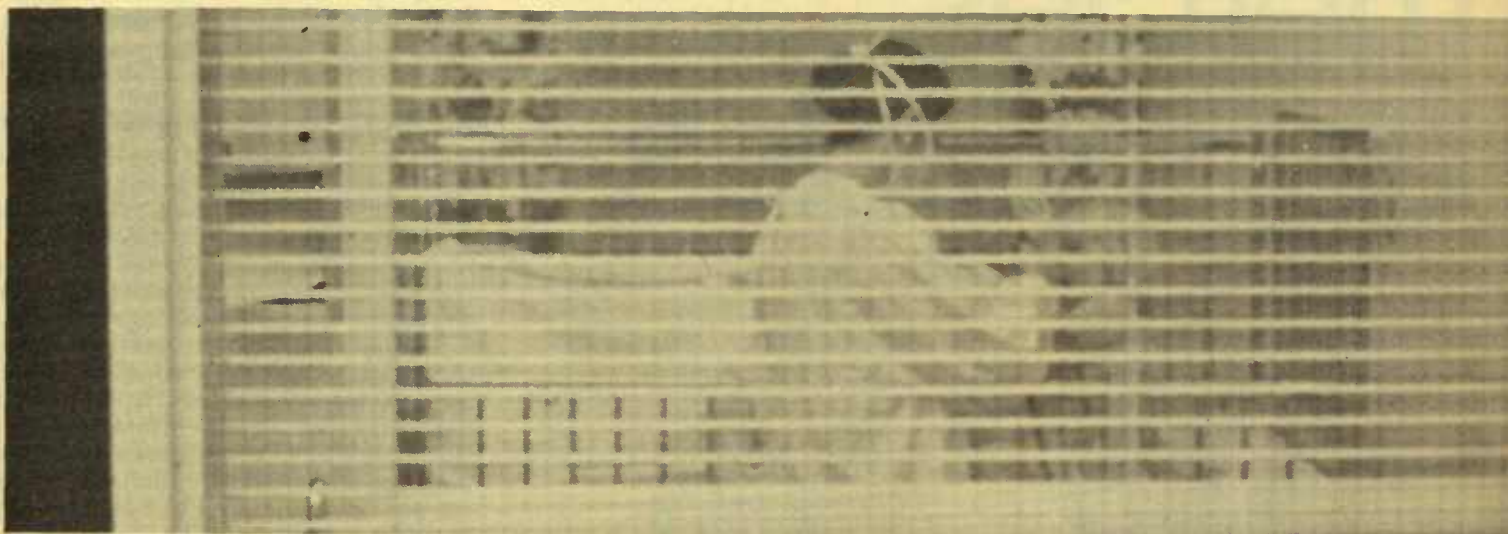
The keys to meeting the consent criteria are awareness and communication. The nurse's role in the latter is important. She is the link between the patient and the physician on whom the informed consent onus falls.

In this the nurse has a unique role: facilitative and preventive. The nurse should know what the patient has been told so that she can better assess the patient's response to the information. She can more effectively allay the patient's anxieties, identify and correct any misunderstandings if she knows the ambit of the physician's disclosure.

The ambit of physician disclosure includes information the physician judges the patient should not have. The nurse must have knowledge of what must remain undisclosed in order to avoid inadvertent disclosure to the patient. Clearly open communication between physicians and nurses is essential.

Nurse/Patient Communication

For the hospitalized patient, the nurse ordinarily is the most visible and available professional person. She is the one most likely to be aware of the patient's current problems and concerns. It is the nurse's responsibility to communicate the patient's anxieties to the members of the health team to facilitate the patient's recovery.²²



Photos by Children's Hospital of Eastern Ontario

If the nurse reasonably believes that the patient's information is inadequate, inaccurate, or misunderstood, she has a duty to inform the physician. The physician may be absolved of responsibility when relying on the nurse's professional competence. The nurse's role is to complement the physician not to undermine him.²³

Competency and adequacy of communication are important ingredients in giving good nursing care. With regard to consent, if the nurse is unaware of the relevant criteria, fulfillment of professional responsibility may be wanting.

The nurse can also deal more effectively with a patient's refusal to consent if there has been sufficient communication between physician and nurse, and if the nurse has a working awareness of the legal doctrine of consent.

Conclusion

Professionalism demands knowledge and understanding of the law applicable to one's profession. Formerly, nurses have not felt the need to be apprised of nursing's legal aspects; today such knowledge is essential.

"With the scope of nursing actions increasing and broadening, it is imperative that nurses understand the legal implications — responsibilities and rights — of their actions. The concepts of the health team, the expanded role of the nurse and the complexity of a technologically-oriented society support our contention of the need for nurse practitioners, education, researchers and nursing students to be knowledgeable of Canadian law."²⁴

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- 1 A similar situation occurred in the recent Ontario case of *R. v Williams et al*, March, 1976 unreported, dismissed on other grounds.
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- 3 *Id.*, at 26.
- 4 *Schloendorff v Society of New York Hospital* 211 N.Y. 211, 128; 105 N.E. 92, 93 (N.Y.C.A.).
- 5 Fleming, *op. cit.*, at 80.
- 6 *Lamphier v Phillips* (1838), 8C & P 475 quoted with approval by Hodgins, J.A. in *Kenny v Lockwood*, (1932) O.R. 141 at 153.
- 7 Willig, Sidney *The nurse's guide to the law*. Toronto, McGraw-Hill, 1970, at 20.
- 8 *Dowey v Rothwell*, (1974) 5 W.W.R., 311, 49 D.L.R. (3rd) 82 (Alta., S.C.).
- 9 *Wilson v Swanson*, (1956) S.C.R. 804 per Rand J. at 812.
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- 11 *O'Brien v Cunard S.S. Co.* 28 N.E. 266 (1891, Mass.).
- 12 *The Public Hospitals Act*, R.S.O. 1970, c.378, R.R.O. 1970, O.Reg. 729, s.49.
- 13 *The Public Health Protection Act*, S.Q. 1974 c.42 s. 36.
- 14 *Hobbs v Kizer* 236 F. 681 (1916).
- 15 *Mohr v Williams* 195 Minn. 261, 104 N.E. 12 (1905).
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23 *Schrader op. cit.*, note 21 at 668.

24 Good, Shirley R. *Contemporary issues in Canadian law for nurses*, by ... and Janet C. Ker Toronto; Holt, Rinehart & Winston, 1973. at vii

Corinne Sklar who wrote "Legal Consent and the Nurse" is also the author of "You and the Law," a monthly column in *The Canadian Nurse*. "You and the Law" is intended to help nurses examine, understand and sort out the legal tangles that surround practice today.

Sklar is currently a third-year student in the Faculty of Law at the University of Toronto. She received her Bachelor of Science in Nursing degree from the School of Nursing at the University of Toronto in 1964. Three years later, she received her Master of Science degree from the University of Michigan in Ann Arbor where she specialized in psychiatric nursing. She was elected to Sigma Theta Tau, Nursing Honorary Society while studying at the University of Michigan.

Of her venture into column writing for CNJ she says, "It is an exciting prospect to be able to combine the knowledge I have obtained in both my fields of study and I look forward to sharing it and stimulating nursing thought in the legal area."

"You and the Law" appears on page 10 of this issue.

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small mercies.... big miracles

Part two

Frances Wirvin



Six months after a closed mitral commissurotomy, author Frances Wirvin again found herself in hospital, this time with bilateral carotid aneurysms. In part two of her story, she helps us to understand what it feels like to co-exist with a 'time bomb' for five long weeks.

"I feel fantastic, you've no idea how great I feel since my heart operation last October." It was April 5th 1977, and I was talking to Mrs. H., a nursing supervisor at the Grace Hospital. I was returning to the office with Sue after teaching our prenatal classes. Sue and I conducted the Tuesday night sessions.

Mrs. H. and Sue were talking. As I was standing there waiting, I suddenly felt what can only be described as a WHAM to the back of my head. WHAM, WHAM, WHAM — with every heartbeat. I felt my heart skip a beat, very uncomfortably. The pain stunned me. Mrs. H. was looking at me and saying "Are you alright?"

"No, the pain in my head, it's unbearable."

Bye-bye Frances

They didn't waste a moment, those two. First thing I knew I was in the office. As I sat down and put my head on my arms, I thought, 'I've got to be dying with this pain in my head. I've just got to be dying with this pain.' I tried to shrug off the feeling.

Mrs. H. quickly checked my blood pressure and told me it was 160/90 — well, that was phenomenal — I told them my normal B.P. was only 90/60. Apparently I also said, though I can't remember, "I'm hemorrhaging, I know I am." The girls just looked at one another.

I was taken to the case room to lie down. Meanwhile, my G.P. was called. When he heard that my B.P. was 160/90, he said "I'll be in immediately, call an ambulance, we'll take her to emergency at the Civic." Before I knew it, he was beside me.

The ambulance came. As I was being lifted in, I felt everything swirling, going black on me. In a panic, I called on Sandie, who was coming with me. Sue and my G.P. were following. My husband Joe had been called and was on his way with a friend.

Things seemed to be happening so quickly. I was admitted to the observation unit in emergency, had skull x-rays — they were so painful for me — and received an

injection for the awful nausea. The neurosurgical resident was called. I was to be admitted to the neuro room in the intensive care unit for observation. Thinking back, I can only remember shivering attacks that made my back arch painfully, and being extremely thirsty.

I was admitted under the care of Dr. P., the neurosurgeon. The next day I was to have a cerebral angiogram. It was assumed that I had an aneurysm.

I remember that night only vaguely. The nurse checked me constantly — my reactions, blood pressure, pulse, hand grip strength. Because I had photophobia, it was very annoying to have a light shone in my eyes to check for pupillary reaction.

The following day my cardiologist appeared, looking visibly upset, and said "You know Frances, if this had happened six months ago, (at the time of my heart operation), we would have thought it was an embolism." To which I replied with a wave "Oh yeah, bye-bye Frances."

"That's it exactly," he answered.

A dicey situation

Late in the afternoon, I was taken to the x-ray department, and there I met my neurosurgeon for the first time. I was anesthetized for the angiogram, and next thing I knew, I woke up screaming, and I mean screaming. The pain was so bad — I was in a red tunnel and the walls were crashing around me. I screamed so much that apparently I had to be given largactil intravenously.

Before I knew it, I was back in the intensive care unit, ice packs on my neck, my main worry — what was wrong with me. Later the resident came in with the news — I had two aneurysms, bilateral carotid aneurysms, "mirror images." Fortunately, both were accessible but that meant two operations.

I wasn't feeling well at all now. More bad news, my husband was the only visitor allowed in the unit and then only for five minutes at a time. I couldn't read (my favorite pastime), or even listen to the radio. Absolute bedrest had to be maintained. I was not allowed to raise my head.

Needless to say, I became very friendly with the intensive care nurses, and what a bunch they were. I had the same nurses every day, and got to know quite a few of them very well as I was to be in the unit for the best part of my five weeks in hospital.

My thoughts wandered everywhere — I

was in a dicey situation, and knew it. Why did it have to happen to me, and what rotten luck to have two. As to the operation, no date had been set — they wanted me in the best condition possible.

Meanwhile I had been seen by a hematologist. After his visit I was put on a powerful drug called amicar, an agent used to preserve the clot at the bleeding site and thus help prevent further bleeding. The side effect of this drug was thrombophlebitis. My legs were in tensors from the moment I started the drug, and believe me, I never stopped moving them. It was unpleasant to know that amicar was only used in "life-threatening" situations.

A few days after admission, I asked for a mirror; I wanted to see how I looked. My first thought (nurse's instinct?) was "Oh, she is dying, until I realized that she was me and quickly modified my opinion. But I remained frightened. I had been a nurse for a long time and I knew that look. I hadn't recognized myself because my face was not only puffy from the angiogram, but it was also a god-awful color. I kept asking myself how long I would be in hospital before the operations were done. A few days after my admission, I was at least allowed a radio with an earphone, but I found it irritating not to be allowed to read, though I probably couldn't focus anyway.

First operation over

The following Monday at one a.m., I woke up suddenly, my head cleared after days of haziness. It was not until then that everything hit me, and I spent a long night crying about the situation I was in. I'm sure that the night nurse realized that I wasn't sleeping, but she left me until I could talk to her at about six in the morning. We had a long talk. I told her how much it upset me that I hadn't seen the neurosurgeon very often. I realized that he was the best doctor I could have, brilliant in fact, but I was annoyed with the lack of communication. The nurse comforted me and I finally fell asleep close to seven o'clock.

At seven fifteen, I felt someone poking at me repeatedly. "Frances, Frances, Frances." I awakened reluctantly to face the resident. Then I blew up. I gave him a pretty rough time for neglecting to ask the night nurse how I was before he began poking me. I turned on him angrily for the lack of information I was receiving. Then I calmed a little and said "It's really not you I'm mad at. It's your boss, he has never come in to talk to

me properly — just runs in and runs out

That day I received a telephone message from my neurosurgeon. I was to be crossed and typed for six units of blood, and he would be along to talk to me. Sure enough, he came and explained that the following morning I was to have an angiogram — then they would decide on whether to operate or not.

They were going to work on the right-sided aneurysm because it was bigger and because they couldn't tell from my first angiogram which one had caused the initial trouble. He added "It used to be we didn't tell the patients anything, just the relatives." I had to admit he had had a long talk with Joe the night of my first angiogram. But I answered "It surely depends on the patient, doesn't it?"

On the following day, my husband came in to be with me before I went for the angiogram (possible operation). I was given an injection of valium 10 mg and all it did was to start me crying. I couldn't stop. Poor Joe what I must have put him through that morning. By the time I arrived in the x-ray department, the anesthetist took one look at me and said "Don't worry, we'll look after you." He quickly put me out.

I was coming to — it was a dreadful sensation, swirling up out of the anesthetic. Heard the resident talking to the operating room staff and thought "If only you knew how much I could hear, you wouldn't be saying that. I must remember to tell you what you said." (Needless to say, I never did remember).

I was having a dream, or was it an experience? I had a choice to make — I could go to one side or the other. On my right side it was cloudy, on the left — Joe. The clouds were very interesting, curious, but wasn't about to investigate. I had made my choice — I had to go back to Joe — it was too soon to leave yet.

Joe was beside me when I woke up. My face was wet from the oxygen mask, my head a little uncomfortable. It had a big nut and bolt arrangement attached to it with a catheter leading from it to the intracranial pressure measuring machine. My first operation was over.

Small mercies ...

I remained in the intensive care unit for another five days before I was sent up to the neurological floor to await my second operation. I was on bedrest for a couple more days, then gradually allowed up to the

bathroom and finally full privileges. I was really amazed at how weak I was, but what could I expect after hemorrhaging and prolonged bedrest.

I was fine for three days, then gradually started to come down, and I really mean down. Depressed was a mild word for the way I felt. I just couldn't see picking up the strength for the second operation.

I was talking a great deal; my whole philosophy of life was changing and each day seemed like a gift. And yet I just couldn't "see" me home again, and that made me feel strange. Was I going to die with the next operation? I knew I had been lucky with the first one — no residual effects. I still couldn't read very well, one eye tended to be blurry. I found it difficult to concentrate and my memory played tricks. I started to receive letters from friends thanking me for letters I didn't know I had written.

At this point my friends were absolutely terrific — helping Joe with the house, meals and babysitting. The children really enjoyed receiving goodies from all the people who sent over meals. I couldn't thank them enough for their support.

I was impatient to know the date of my second operation; I kept asking and was told "in a couple of weeks." Finally a tentative date was set for April 29th, just over a week away. I don't know whether this information helped or not — I didn't think I could stand the wait or pick up the courage to go through with it. The Saturday before my operation, the neurosurgeon came in and what he said just floored me:

"You will really need to think about whether to have this operation or not."

"I didn't think I had any choice."

"Well this operation will be a lot trickier. The aneurysm is very small and from the angiogram doesn't seem to have much of a neck to it. This makes it difficult for us. It's much closer to the bone."

I was aghast. "I can't see me walking around with a time bomb in my head!" The neurosurgeon replied that he would ask a neurologist "who didn't have an axe to grind" to see me on Monday. Meanwhile he would be out of town until Thursday. Needless to say, I had a long talk with the resident; we were on friendly terms since my blow-up and subsequent apology.

Joe was very annoyed that he hadn't heard anything about this. He was to be with me when the neurologist came. At ten o'clock on Monday morning, the neurologist examined me and then said "In my opinion,

from your angiogram, the first operation report, and what you've told me, it is the left one that has given you the trouble."

"So I don't have any choice. I have to have this operation." "I'm afraid so." We talked for a few more minutes, and then he left.

I just couldn't believe that "it" was still alive; it could blow anytime. How was I going to get through the next few days? I was very agitated, told the head nurse, and the next thing I knew I was on librium 25 mg three times a day. What surprised me was that I wasn't zonked out with such a heavy dose. It did help.

One of my friends visited every day to try and keep me on an even keel. Joe came for lunch every day and when he could in the evenings. My family in Canada, Scotland and Australia were keeping in touch. An obstetrician I had worked with visited me; he had been through the same ordeal the year before and really understood my situation.

Friday came too soon. Joe and his brother were with me. I had insisted that my sister stay at home — she was obviously shattered by the whole business.

I was taken to the x-ray department again before my operation. The neurosurgeon came in and reminded me of the possibilities of paralysis and speech defect. That was all I needed before my anesthetic.

Big miracles...

I didn't swirl up this time — in fact I have only a vague memory of nausea, the wet oxygen mask, and a leaden sleepiness. I wasn't really awake until the next day. Thank God it was over — no paralysis, no speech defect. In the recovery room I had recognized the nurse who was caring for me and had said "Hi Theresa, I feel sick." So when the surgeon called my sister, he was able to give her good news when she asked if there were any residual effects.

I learned later that I had been in the OR for nine to ten hours. Everyone seemed to be going crazy with relief after it was over. It was good to know of their concern. Even the cardiac unit was keeping in touch.

I was now on the usual decadron injections to reduce cerebral edema — these injections were gradually reduced over the week. I was also on dilantin 100 mg three times a day. I'm still taking the dilantin and understand I will be for some time yet. After ten days in intensive care and a few days on the neuro floor, I went home.

At home, I couldn't seem to walk

properly. I kept having shooting pains up and down my legs and across my lower back. On the Sunday after my discharge I felt a slight pain in my groin and ignored it until I realized that my left ankle was swelling and my leg seemed to be a bit blue. I didn't want to think about what it meant. But overnight the pain in my groin became intense and I couldn't sleep.

The next morning my G.P. was called. He returned my call immediately. We had laughed in the hospital over the fact that he could never ignore my calls — so far, they had all been emergencies. He appeared shortly after the call, looked at my leg and said "You know what this means ..."

Back to the cardiac unit with ileo-femoral thrombophlebitis. And there I remained for three weeks. It was early June. My daughter was fed up, complaining that I had been in hospital "since April and now it's June." I was discharged June 3rd.

Now I'm back at work ... doing prenatal teaching once more. I am no longer taking anticoagulants. All I have to do is come off the dilantin and lose the weight I gained in those months of inactivity. My hair is growing well — strange that having it all shaved off had disturbed me so little ...

Small mercies, big miracles. ♡



Frances Wirvin, a Registered General Nurse and a Certified Nurse Midwife, received her nursing education at the Eastern District Hospital in Glasgow and the Bellshill Maternity Hospital in Lanarkshire, Scotland. Emigrating to Canada soon after the completion of her education, Frances has nursed in a wide variety of clinical settings including cardiac and thoracic surgery in Montreal. At present, she is a prenatal instructor at the Salvation Army Grace Hospital in Ottawa.

She is also the president of the Association of Professional Nurses Educated Abroad (APNEA).

It is no small challenge to meet the educational needs of the critical care nurse. Anyone who has tried to set up an effective inservice education program has an idea of just how overwhelming the task may be. Author Laura Worthington began such a program for critical care nurses and the results have been rewarding. Here's how it worked.

ON-GOING EDUCATION IN CRITICAL CARE

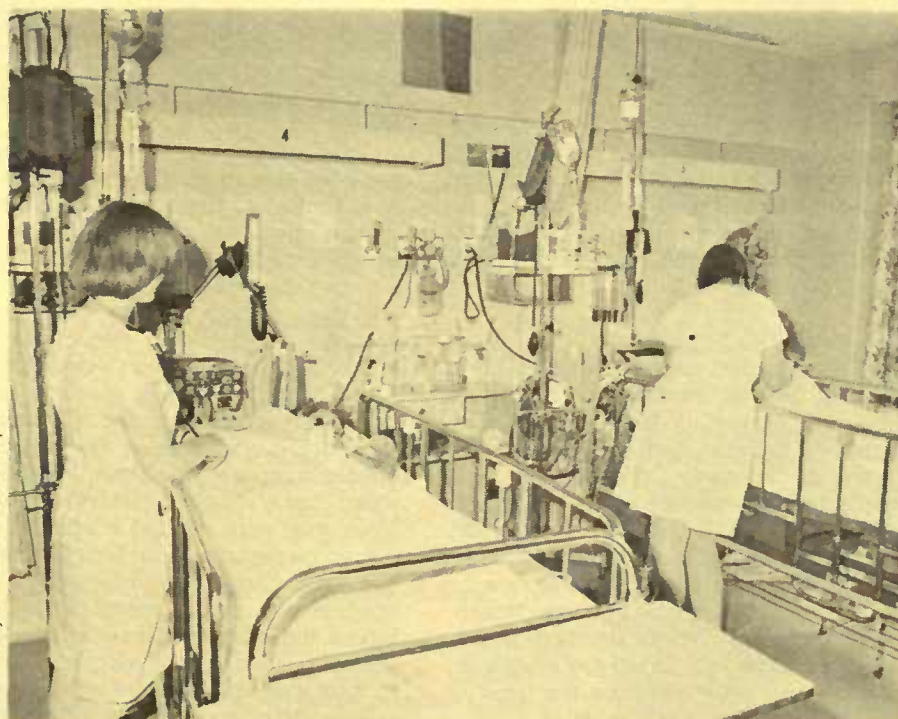


Photo courtesy St. Boniface General Hospital

Laura Worthington

Organizing an in-hospital ongoing education class for critical care nurses can be an overwhelming job. At least that is how I felt last year as I began to set up a course at the hospital where I am a nurse clinician. Now that the first year is over, I would like to share my formula and format with other nurse educators who may find themselves faced with a similar challenge.

Why?

This is the most salient question to ask before beginning an inservice program. Why offer in-hospital education?

In Canada, the answer is all too clear. There is not enough money available to allow large numbers of nurses to pursue post-graduate studies in a formal academic setting. While the situation may differ somewhat from province to province, there is a general lack of scholarships and living stipends available to full-time students. Some nurses struggle along with part-time classes and a full-time job, but the majority are unable to extend themselves to such an extreme.

The other obvious answer to "why" is that the demand is there. I found that after five to six months in an acute care setting, many nurses expressed a desire to learn more about the disease processes of patients they were meeting on a daily basis. The newness had worn off, basic knowledge had been accumulated, and they wanted a "stepping stone" on which to build independent studies. Questions like "Where do we keep the digoxin?" had by that time escalated to "What is an A-a gradient?" or "Which leads do you see an inferior MI in?"

Form Letter to Directors of Nursing Participating Hospitals

Cardio-Pulmonary Review Course for Critical Care Nurses

Objective:

to provide an in-depth review for critical care nurses of the cardiac and pulmonary systems. The symptoms, treatment and pathophysiology of disease processes commonly seen in these high risk areas will be presented. Related system failure i.e. renal, hepatic and cerebral will be presented only as it affects these two major systems.

Subject content will include: blood gas analysis, A-a gradient, cardio-depressant drugs, acute changes in a 12-lead EKG, and the pathophysiology of restrictive and obstructive lung disease.

Eligibility:

the participant must be an R.N. who is presently working in an acute care area. Exceptions will be made for those nurses with a particular interest in this field or past experience in it. These people must contact course organizers for admission approval.

Length:

8 days, Mon. - Thurs., 9 a.m. to 5 p.m. (exact dates)

Place

(Name of institution and conference room)

Fee:

\$50.

How to Apply:

Please contact by phone or mail
(Names of course organizers)

Additional Information:

This course is limited to 100 participants. Enrollment will be conducted on a first-come-first-serve basis.

The hospital where I am employed recognized the need for education and allowed nurses in the critical care areas to attend an eight-day course with pay. Its only mandate was that the program cover issues concerned with acute medicine and the care of the critically ill.

Who?

Attendance at such a class can be the first major stumbling block for the organizers. In the past, our program allowed any nurse who was interested to attend, as long as she was from our hospital.

This arrangement had proven unsatisfactory. Nurses from other areas who had never worked with monitors, pressure transducers and respirators found it hard to comprehend many of the lectures. On the other hand, RNs from the intensive care units felt that many of the classes were too basic and lacked any real challenge. It was impossible to please these two audiences.

For this reason, we decided to break with tradition and restrict attendance to nurses working in critical care areas. This drastically reduced class size, and to offset the problem, we opened the class to acute care nurses from other hospitals. We publicized the program via form letters sent to each hospital in the metropolitan Montreal area (See Figure 1). This was time-consuming and involved many hours of secretarial work. In another six months, when the course is offered again, our provincial nurses association will provide for the publicity, screening of applicants and collection of fees for the course.

Applicants from outside the hospital were asked to pay a fee. This helped to

ease the cost of printed material and audiovisual equipment. But we also hoped to make money for our in-hospital education fund. Because the nurse-clinicians involved took time away from their clinical areas to organize their presentations and speak to the class, we thought that our nursing staff should be repaid in some way. By charging a fee of fifty dollars, our education fund became \$1,400 richer.

What?

The content of the course is the biggest area of concern and demands the most work from the organizers. Our previous program had gone under the name of "Intensive Care Course." But eight days is too short a time to present all the disease entities, problems and equipment related to a critical care area.

It was decided to give the new revised course two core threads: cardiac and pulmonary. We felt that both these systems came into play in any acutely ill patient and were therefore the most appropriate to present in detail.

The organizers also believed that nurses, as well as other health professionals, should be asked to speak. As you can see from the course outline, (Figure 3) we were able to maintain a 50-40-10 speaker ratio of nurses, doctors and paramedical personnel.

Many nurses, although skilled and knowledgeable, had never had an opportunity to speak in a formal setting. This opportunity proved to be a learning and growing experience for them as well as for their audience. Although "nerves" were a constant problem with these untried speakers, this arrangement turned out to be an unqualified success. Our speakers asked to return and

present lectures at the next class! We remain convinced that staff nurses are an unexplored natural resource for such courses, one that no course organizer should overlook.

By presenting only two core threads we were able to go into great depth on specific topics. Briefly, the course was broken down into:

- two days cardiac
- one day cardiac drugs
- three days pulmonary
- one day fluid and electrolytes
- one day review and evaluation.

A bibliography was given to each participant. It contained about 30 articles geared to help introduce the learner to concepts presented in class. In order to make these readily available to the class, they were xeroxed in triplicate and placed on reserve in our hospital library.

To enhance continuity, each speaker was sent a memo a month before the class with four to five key points to cover in the lecture. The lecturer was also provided with a course outline and bibliography so that he knew what type of preparation the audience had before he spoke. A sample memo is reproduced here for your information (See Figure 2). This little extra provided amazing symmetry and cohesiveness from lecture to lecture — quite a feat when you consider that 35 different people were presenting.

Unfortunately, the size of the class and the layout of our facility prohibited bedside experience during the program. This problem was offset as much as possible through the use of case histories and problem sessions where the participants were asked to think, extrapolate and apply their knowledge to the clinical setting. This is not an

Memo

Program Speakers

As we discussed I would like you to speak on *Aneurysm of the Ventricle* at the forthcoming cardio-pulmonary review course.

It would be helpful if you included in the lecture:

1. Causative factors
2. Presenting clinical symptoms
3. Appearance on X-Ray
4. Medical and Surgical Management
5. Post-operative care.

Your presentation is scheduled for
The program will be held in
A portable X-ray viewing box will be available at all times.
Should you require other audiovisual aids please let me know. If for some reason you cannot attend I would appreciate at least 24 hours notice or your arranging for a speaker to replace you.

alternative to clinical experience, but the best substitute we could provide.

We did not conduct a preassessment of the class, but we hope to do so next time. Post-class assessment consisted of four case histories which the nurses were asked to review and comment upon. They had become accustomed to this approach throughout the class sessions.

Looking back

The positive response to our course was overwhelming. In a post course evaluation, participants stated that they found the sessions contained information at an intermediate to advanced level. None of the lectures were found to be esoteric or boring. And most important, the participants stated unanimously that they would recommend the course to their co-workers.

Critical care nurses need, want and are willing to participate in ongoing education. As nurse educators, we cannot ignore their needs. For the nurses working in critical care areas in our hospital, we have found that the type of program I have just described helped to meet those needs. ♡

Author Laura Worthington is presently working as a nurse clinician at the Royal Victoria Hospital in Montreal, specializing in cardiopulmonary medicine. Since her graduation from the University of San Francisco, the author has been employed in critical care areas in Los Angeles, San Francisco and Vancouver. In 1975, Laura obtained a master of science degree in biological dysfunction from the University of California, San Francisco, Ca.

Course Outline

1st Week

Monday

Introduction and Course Overview
Nurse Clinician

Anatomical Principles of the Heart
Nurse Clinician

Coronary Artery Circulation
Cardiologist

Interpretation of 12 Lead EKG
Cardiologist

Practice Session (12 Lead)
Nurse Clinician

Tuesday

Acquired Valvular Heart Disease
Cardiologist

Congestive Heart Failure
Head Nurse, Cardiac

Congenital Defects
Cardiologist

Aneurysm of the Ventricle
CVT Surgeon

Heart Sounds
Cardiologist

Cardiology: Case History
Nurse Clinician

Wednesday

Autonomic Nervous System
Nurse Clinician

Sympathetic and Parasympathetic
Drugs in Heart Disease
Nurse Clinician

Cardiac Depressants
Nurse Clinician

Vasopressors
Staff Nurse, Recovery Room

Vasodilators
Head Nurse, Recovery Room

Study

Thursday

The Respiratory Pump
Nurse Clinician

The Pulmonary Circulation
Respirologist

The Exchange of CO₂ and O₂ Within
the Lung
Respirologist

Arterial Blood Gases
Nurse Clinician

A-a Gradient
Nurse Clinician

Practice Session (Blood Gases)
Nurse Clinician

2nd Week

Monday

Restrictive and Obstructive Lung
Disease
Nurse Clinician

O₂ Therapy for the COPD Patient
Inhalation Therapist

Lung Volumes:
Predicted and Abnormal's
Respirologist

Pulmonary: Case History
Nurse Clinician

Study

Tuesday

Adult Respiratory Distress Syndrome
Anesthetist

Acute and Chronic Respiratory
Failure
Respirologist

Review of Pulmonary Questions
Nurse Clinician

Review of Cardiology Questions
Nurse Clinician

Study

Wednesday

Extracellular Fluid Volume Control
Nephrologist

Fluid Therapy in Relation to the
Patient with Head Trauma
Nurse Clinician

Fluid Therapy in Acute Renal Failure
Nephrologist

Fluid Therapy in the Burn Patient
Accident Service

Fluid Therapy in Uncontrolled
Diabetes Mellitus
Endocrinologist

Thursday

Legality in the Critical Care Area
*Head Nurse, Emergency Nurse
Clinicians*

Rap and Review

Study

Case Histories
Course Evaluation

Nursing — a suitable case for treatment

Rosemary Long

You can pick them out anywhere. They become animated only at the mention of the words 'pressure area.' Mention 'pressure sore' and there's no knowing where the exchange might lead. Midwives light up with interest on the receipt of the information 'Baby has passed meconium.'

Nurses come in layers. They have to be hierarchical for identification purposes. As they go up the layers they discard their protective uniform with regret (then nobody knows who they are) and they take to wearing man-made fibers as they never have time to iron things. This is because they are always at meetings. Because they are always at meetings, they don't read fashion magazines or go shopping, so they wear their skirts (female that is) two inches above the knee three years after this fashion went out of date. Because of their short skirts, sympathizers can see the varicose veins in their popliteal spaces.

Since Halsbury, [charter developed from Report of the Committee of Inquiry into the Pay and Related Conditions of Service of Nurses and Midwives, 1974] nurses have taken on a new form of poverty called 'the mortgage' because they didn't know how to spend the extra money. Now they talk powerfully about rising damp, drains and the art of growing tomatoes and mint.

Megalomaniac

Nurses quickly become power-crazed — usually by the age of 19 1/2. It starts when they first look round the sluice and get the concept of fluid balance via the visual and olfactory aids provided. The observation of and filing of other people's personal end products is a good nursery for the budding megalomaniac. The first taste of power, when left in charge of the skin ward [dermatology] on a Sunday morning, can leave an embryonic ward sister [head nurse] trembling on the brink of 'what it's all about' as she does a round with the Oily Calamine and the Phenergen (promethazine hydrochloride).



In the rarified atmosphere of the nursing academic world (hands up who knew we had one) there is a lot of talk about the nursing process going on. This is usually in terms of what the patient is receiving. There are, however, also distant whispers about what nursing does to the nurse.

Nurses work hard participating in the alleviating or not alleviating of some of life's more gruesome episodes. Modern nursing is still relatively young as a profession and we have not yet arrived at the point where we really have considered in any depth what the nursing process does to the nurse.

In all sincerity, a group of nurses were recently asked in a social situation, if nurses ever experienced compassion. There is a myth in the mind of the public, and within the profession itself, that nurses have no feelings. Nurses are themselves very odd about other nurses' feelings. If one is upper middle class, it's not done to react. If one is working class, then the response is 'You're soft.'

Most nurses are somewhere in between and are just bewildered underneath their starch or its substitute.

All of a sudden, full of enthusiasm, clutching the appropriate educational qualification (anything goes from the GNC [General Nursing Council, RN's] test to an MA degree in medieval history) and a desire to help people for riveting psychological reasons, our new nurse is confronted by some bizarre human situations. This young person may be required to nurse someone of his/her own age who is dying, or admit a baby with exomphalos with its terrified mother, or obtain a midstream specimen of urine (MSU) from an old lady who looks like granny.

The ultimate irony of our caring profession is the lack of care that nurses can have for each other. 'Going off sick' is weak, naughty or slightly rude. If people show signs of stress they 'don't have the calibre' or 'what it takes.' Try saying dysmenorrhea to a woman who has never had a twinge.



What happens?

What happens to nurses?

Frequently the ones with the most potential leave before completing their training. Some nurses leave nursing to do research into nursing; they find out very little or else they produce statistics proving what everybody knew before.

Some nurses marry and have children, as is the way of the majority. The women who have happily fulfilled their biological function often want to return to nursing when their husbands aren't there. The nurses without husbands/wives/lovers don't want them back because they only want to work on Tuesday, Wednesday and Thursday mornings, leaving the unmatched working at the times when people meet people. So they refuse to organize day care centres. Male nurses watch all this and then take over.

Other nurses go and work overseas and get out of date. Some nurses leave nursing and learn how to collect up paper and then redistribute it on a clipboard. This is when major training in meetings begins. These nurses are called nursing officers (administration) [assistant directors of nursing] or sevens (b) [nurse teachers].

Other nurses go to college for another certificate. This takes two years, or one year for masochists. They then get paid about 2 pence more than the ones who didn't wear their eyes out. These nurses go into education, effectively changing their jobs completely. They then tell everybody else how to do their jobs, only nobody listens. It is necessary to have gadgets to do this job properly. These sevens (a) are heard muttering "OHP" (overhead projector) and "tape-slide" (self-explanatory?) because they can't

learn to use chalk and write on the blackboard, or felt-tipped pens, alas, on a writing surface. The abbreviations, like all abbreviations, are to confuse others and exclude them from an 'in group.' The nurses think they have to use gadgets as the art of lecturing has been lost.

Vanishing point

Both administrators and tutors eventually disappear into the unknown territories called 'division', 'district' and 'area'. They are then never seen again. It is said they never iron a thing, they become experts in biodegradable waste products from their kitchens and they collect useful clothes in sales (late shopping only).

Nurses are funny people. They have such broad responsibilities and so often view them unimaginatively. It is hard for nurses to penetrate their own defensive armor. From the comfort of not nursing actively for a little while it has been hair-raising to take a look at what nursing is before plunging back into it again. Nursing, surely, is a bottomless pit. At the end of every day the thoughtful nurse will have to conclude that most tasks, most encounters could have been conducted either differently, or better. Maybe it is all too much at the end of the day. The body and the mind ache with a thousand fatigues, from the cardiac arrest to the spider in the bath, and the abortive urine save. The nurse who is too shattered to think any more or the one who was never taught to start thinking may slide gently to the banal exclamation 'Your 10th baby Mrs. Quickfall, how absolutely marvellous.'

The area of the nurse's life that is sacrificed on the altar of the district

general hospital is not infrequently both her body and her mind. A job like nursing, more than many others, asks for the skills and energies of personalities who have had the opportunity to mature.

Boring

There are some hopeful signs that the profession is coming of age in some areas, but too many nurses are weary and boring.

Part of the problem is that nurses believe they should have all the answers and that they should be ready to serve them up with the temperature chart and the ampicillin. There is a place for the nurse to provide the security of temporarily relieving patients of their responsibilities. But what real answer can anyone give to a question like, 'Whatever will my husband do when he sees my colostomy?' The nurse is not in a position to give the answer as she does not know. What tools may the nurse use, not only to escape her own omnipotence or sense of failure but to enable the patient to arrive at the answer to her own problem? For the nurse to provide an answer would be trite, glib and unhelpful.

In common with many other professions explaining human relationships, there are some areas that promise a little relief. Our colleagues in the psychiatric field are taught to develop their interpersonal skills and turn unanswerable questions back to the questioner. These skills have alarming labels like 'reflective counseling', which tend to send nurses and midwives scurrying for cover. Perhaps the really sad thing is that nurses like to think they have all the answers.

Any real teacher may appreciate that the greatest pleasure in teaching is in guiding learners to the point of discovery so that knowledge becomes their own. It is theirs — not borrowed or stolen.

There are encouraging signs that after only 100 years or so of professional nursing, we are now ready to take a good look at ourselves. What does constant exposure to human misery do to us? What do constant hard, debilitating infections and irregular hours do to us? Why do we sometimes become boring and tedious to other people, not to mention ourselves? Is it necessary? Is it curable? Is it preventable? ♣

Rosemary Long is a tutor student, Queen Elizabeth College, University of London.

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Resumes are based on studies placed by the authors in the CNA Library Repository Collection of Nursing Studies.

Research



• Spouses' Responses

The Depressed Woman's Husband: His Response to Her Return Home Following a Psychiatric Hospitalization. Toronto, Ont., 1977. Thesis (M.Sc.N.), University of Toronto by Louise S. Lemieux-Charles.

This study examined the response of the husband to his environment following his wife's first psychiatric hospitalization for depression and her subsequent return home. The ultimate purpose was to identify those variables which affect the family's response during the post-hospital adjustment of one of its members.

Twenty husbands were interviewed two weeks following their wife's discharge from hospital. Data were collected using a semi-structured interview schedule developed and administered by the investigator. The husbands' responses were analyzed under the following headings:

- perception of his wife's present behavior;
- personal response to his wife and to her return home;
- response directed at a change in his environment;
- response directed at maintaining stability in his environment.

The findings demonstrated that the majority of husbands were relieved their wife had received help. They expressed confidence about the future though many did worry that their wife was going to become ill again. Nine husbands who were either angry or puzzled about the treatment their wife had received or their non-involvement in her care were among the 75% of those who were not involved either singly or with their wife in any treatment modality. A finding of interest was in the expressive domain where nine husbands stated that they preferred not to speak to anyone about personal problems and chose to be alone when feeling depressed or down. However, this finding was not statistically significant, when the above group was compared on the variables of age, years of marriage and social class with those husbands who chose their wife as confidant.

The majority of husbands now perceived their wife and themselves as getting along better than most couples they know. Upon her return home, the majority of wives resumed their household and familial responsibilities. Misunderstandings occurred both in the marital relationship and in relation to the division of household and familial responsibilities. For the majority of husbands, their activities, both with friends and at work had remained unchanged.

Implications were stated for nursing practice and research. Generalizations were not possible because of the size and nature of the sample. However, a beginning analysis was made in the study of the feedback processes involved between the husband and his environment especially the interpersonal dynamics of the marital relationship. Recommendations were made regarding the type of nursing intervention which would be most helpful to the family during this post-hospital period.



• Community Nursing

A Study of Specific Psychosocial Needs of Mothers of Preschool Children with which Community Health Nurses Could Assist. Toronto, Ontario, 1977. Thesis (M.Sc.N.) University of Toronto, by Lydia Joan Brailey.

The primary purpose of this study was to identify and describe specific psychosocial needs of mothers of preschool children with

which community health nurses could assist. The ultimate purpose was to contribute to an improvement in community health nursing service to mothers of preschool children.

For the purposes of this study, psychosocial needs were defined as the assistance which a mother perceived she required in achieving two of her developmental tasks: 1) achieving confidence in her role of mother of a preschool child and 2) reconciling conflicts in her roles of wife, mother and autonomous person.

Fifty mothers whose first children were two or three years of age were selected through six nursery schools and were interviewed on one occasion in their homes. Data were collected using a structured interview schedule developed and administered by the investigator.

The data showed that the mothers had a wide variety of numbers and kinds of concerns regarding their children's behavior and development. Eighty-eight percent of mothers reported that they were often or sometimes confused about how to handle their children's behavior or training. Ninety percent perceived that counseling or classes in child care would be helpful to them. The two topics chosen by the most mothers were 'children's emotional needs' and 'child behavior.'

Fifty-eight percent of the women reported unresolved conflict between their roles of mother and autonomous person. If group discussions with other women about these conflicts in roles were held in their neighborhood, sixty-six percent would plan to attend. There was little evidence in this study of conflict between the roles of wife and either the roles of mother or autonomous person.

Forty-six percent of the mothers were assessed by the interviewer as satisfied with their current life situation; forty-four percent to have mixed feelings and ten percent as dissatisfied. Although eighty-six percent of the sample had attended prenatal classes, many expressed a need for better preparation for motherhood. Only twenty-two percent of the sample had attended

any other form of parent education classes and many of the others were not aware that such classes were available.

Implications were stated for nursing practice, education and research. Generalizations are limited because of the size and nature of the sample. However, these specific psychosocial needs of the mothers were identified and recommendations were made towards improvement of community health nursing service to mothers of preschool children.

• Acupuncture

Auricular Acupuncture for Smoking Withdrawal: An Experimental Study. Halifax, N.S. 1977. Thesis (M.S.), of the School of Physical Education, Dalhousie University by Valeria J. Gilbey.

This study was undertaken to determine if press needles inserted into correct and incorrect acupuncture points for a period of one week would produce a difference in abstinence and mean reduction rates in cigarette smoking at one week, one month and three months after treatment.

Ninety-two subjects, age 30-39 were randomly assigned to experimental and control groups. All subjects received acupuncture treatment on the same day and the needles were removed one week later. Interaction between the acupuncturist and subject was minimal. Subjects were told press needles would be placed in one of two areas. Forty-four subjects comprised the experimental group (lung area), and 48 subjects the control group (kidney area).

Chi square analysis at the three observation periods showed that there was no significant difference between groups in relation to abstinence. Analysis of variance with repeated measures indicated that there was no significant difference between the two groups in respect to mean reduction rates of cigarette smoking. At three months, 20.5% of the experimental group and 14.6% of the control group were not smoking.

Names and Faces



Ella MacLeod (B.N. McGill University; M.S., Boston University) resigned as director of nursing of the Prince Edward Island Hospital to accept the position as the nursing director for Prince Edward Island's Department of Health. She brings to the position a number of years of experience in teaching, and in administering a school of nursing, public health nursing, and hospital nursing service administration. As well as the above degrees, she holds a certificate in Hospital Organization and Management.

In her new position, MacLeod will be responsible for the staff and programs in public health nursing including Home Care. She will work in the planning and development of new programs and research projects within the Department and will serve as the Department of Health's contact concerning all matters of interest and relevance to nursing for intra-departmental, provincial and federal persons or agencies.

Dorothy Nelson director of the Extension Course in Nursing Unit Administration (NUA) is retiring from that position this Spring.

As director of the program since 1965, Nelson has seen the NUA program grow so that now, more than 500 nurses from across Canada enrol in the nine-month course each year. Sponsored by the Canadian Nurses Association and the Canadian Hospital Association, the program includes both correspondence lessons and workshops geared for nurses working in managerial positions.

Dorothy Nelson is a graduate of the Saskatoon City Hospital School of Nursing. She obtained her certificate in Nursing Education and a B.A. degree from the University of Toronto and a B.S. degree from Teachers College, Columbia University. Her experience includes general duty nursing and teaching in a wide variety of settings.

Assuming the position of director is **Mary E. (Sally) Robertson**, (B.Sc.N., Mt. St. Vincent University, Halifax). She will be assisted in her new post by **Dorothy Cram**, (B.A., B.Sc.N., University of Saskatchewan), who will take over from Carole Carruthers as assistant director of the NUA program. Currently, both Robertson and Cram are enrolled in the Master's degree program in Health Administration at the University of Ottawa.

Mary Gibbon, director of the Hamilton-Dundas Branch of the Victorian Order of Nurses, has been named Hamilton's Woman of the Year for 1977. She was selected as recipient of the award by the Status of Women Committee for "putting more than 100% effort into her job and touching the lives of thousands of people each year."

In her 31 years as a nurse, Mary Gibbon has had a variety of experiences in nursing. She spent her first five years in outpost nursing in northern Ontario, and then began working as a staff nurse with the VON in Hamilton. She has also acted as regional supervisor in the Huntsville area, and started a home care program in the rural areas around Guelph.

Her most recent interest has been in the field of geriatrics. Mary spent last summer conducting seminars across Canada on care for the chronically ill, and says that one of her main goals is to help younger people see the elderly as human beings.

Mary has also found the time to write two books, one about her experiences as an outpost nurse, and one about the history of Hamilton mountain.

New Appointments

Dalhousie University School of Nursing announces the following new faculty appointments:

Barbara Devine (R.N., Yarmouth, N.S.; D.P.H., Dalhousie; B.Sc.N., Mount St. Vincent University; M.A., Sociology, Dalhousie) will be teaching in the School of Nursing and will be involved in the development of nursing research; **Joan Fischer** (B.N., Memorial University) is presently working on her Master's of Education degree at Dalhousie. Her work experience includes general duty nursing in hospitals in British Columbia, Manitoba and Ontario. She will be working with second year basic degree students in both the classroom and the clinical setting; **Nancy Grant** (R.N., Montreal; B.Sc.N., M.Sc.N., University of Western Ontario; Ph.D., University of Edinburgh) is teaching in the Master's program. Her particular research interest is the study of nursing workload;

Geraldine Hart (R.N., Halifax; Nursing Administration Diploma, Dalhousie; B.N., McGill) comes with experience and special expertise in the area of rehabilitation nursing and will be working with students enrolled in the B.N. program for registered nurses;

Janet Hatt (R.N., Halifax; B.N., Dalhousie) will be a full-time faculty member in the first year basic degree program;

Myrna Slater (B.Sc.N. University of Toronto; M.P.H., University of Minnesota) brings a wide variety of experience in teaching, administration and community health nursing to the Dalhousie faculty; **Martha Zed** (B.N., University of New Brunswick; M.N., Dalhousie) has specialized in medical nursing and will teach first year basic degree students;

Jean Hughes (M.Sc.N., Boston University) has returned to teach in the school of nursing at Dalhousie University after completing a Master's degree preparing her as a specialist in mental health and psychiatric nursing. She received a \$1500. bursary from the Great West Life Insurance Company upon her return.

Dorothy Knight (B.Sc.N., Toronto) has been appointed executive director of the Ontario Physiotherapy Association, the first in the association's history. There are now 2,000 physiotherapists in Ontario, the largest single group in Canada.

Knight comes to the position with a broad background in the health care field as a nurse, advisor and administrator in international, national and provincial public bodies, voluntary associations and professional organizations.

She has worked with the World Health Organization in Africa where she planned, organized and monitored a multi-disciplinary basic health service. She was involved in writing legislation governing the health disciplines in Ontario and has directed a staff of specialized community development workers in the rehabilitation of physically disabled adults. Her experiences in Canada's Arctic are chronicled in a book by Betty Lee, entitled *Lutiapik* (McLelland and Stewart, 1975).

Three New Brunswick nurses have been awarded the Queen's Silver Jubilee Medal in appreciation of their national contribution to nursing. They are:

Jean Anderson, past executive secretary and past president of the New Brunswick Association of Registered Nurses;

Margaret G. McPhedran, past dean of the U.N.B. School of Nursing; and

Apolline Robichaud, director of public health nursing, New Brunswick Department of Health, and past president of the NBARN.

All three nominations were submitted by New Brunswick health related organizations.

Margaret Power (R.N., Halifax Infirmary School of Nursing; B. Sc.N. Mount St. Vincent University) was appointed director of nursing education at the Grace Hospital in Halifax. She was formerly on the education staff of the Halifax Infirmary.

Texts they'll use as students... References they'll use as practitioners. Turn to **Mosby** here's why:

New 6th Edition!

ALEXANDER'S CARE OF THE PATIENT IN SURGERY. Long respected for its accuracy and completeness, this classic text provides a comprehensive overview of safe, efficient OR nursing. In this superbly illustrated new edition, extensively revised and updated chapters first explore — in depth — such topics as administration, asepsis, positioning, instrumentation, and wound healing. Subsequent chapters — organized by anatomical and physiological specialties — describe and graphically demonstrate various techniques and procedures. More than 2,000 illustrations highlight discussions. Throughout, a new emphasis on nursing assessment and responsibilities offers students a deeper understanding of their role on the OR team.

By Marie Rhodes, R.N.; Barbara J. Gruendemann, R.N., B.S., M.S.; and Walter F. Ballinger, M.D.; with 22 contributors. March, 1978. Approx. 800 pp., 2,146 illus. **About \$26.50.**

TENTATIVE CONTENTS (abridged) · Concepts basic to operating room nursing · Design of the surgical suite · Instruments, sutures and needles · Breast surgery · Thyroid and parathyroid surgery · Gastrointestinal surgery · Thoracic operations · Vascular surgery · Reconstructive plastic surgery · Ophthalmic surgery · Pediatric surgery

A New Book!

INSTRUMENTATION FOR THE OPERATING ROOM: A Photographic Manual. Help make your students' first OR experience less confusing. Reflecting the vast range of surgical procedures — each with its own instrumentation requirements — this practical text offers students valuable information on all commonly used contemporary surgical instruments. Ranging from the simple to the complex, instruments are described, including their name, proper usage, appropriate cleaning procedures, and correct sterilization methods. More than 900 superb illustrations help make this resource a comprehensive introduction, practical review or self-testing vehicle.

By Shirley M. Brooks, R.N., B.A. July, 1978. Approx. 350 pp., 908 illus. **About \$13.50.**

TENTATIVE CONTENTS · Endoscopy · Special studies or diagnostic procedures · Minor surgery · Basic laparotomy · Abdominal surgery · Breast surgery · Operations on genitourinary organs · Operations on the large blood vessels · Orthopedic surgery · Neurosurgery · Thoracic operations · Cardiothoracic operations · Ophthalmic surgery · Operations on the ear, nose, and throat · Reconstructive plastic surgery

FUNDAMENTALS

A New Book!

TECHNOLOGY FOR PATIENT CARE: Applications for Today, Implications for Tomorrow. Turn to this unique text for a thorough introduction to the impact of technology on patient care. Ideal for students lacking advanced mathematics or engineering backgrounds, it discusses various monitoring, diagnostic and treatment systems, and reviews basic electrical safety concepts. By Joseph D. Bronzino, Ph.D. June, 1977. 270 pp., 135 illus. **Price, \$11.50.**

New 2nd Edition!

PROBLEM-ORIENTED MEDICAL RECORD IMPLEMENTATION: allied health peer review. Written by nurses for nurses, this dynamic text offers detailed guidelines for implementing and maintaining an effective POMR system. Students will benefit from the new, sample problem-oriented forms for both acute and long-term facilities. By Rosemarian Berni, R.N., M.N. and Helen Readey, R.N., M.S. April, 1978. Approx. 224 pp., 50 illus. **About \$8.15.**

MEDICAL/SURGICAL

New 9th Edition!

ORTHOPEDIC NURSING. This definitive text will help students develop the necessary skills for planning and implementing holistic care of the orthopedic patient. Timely new features include an innovative chapter on emergency nursing in the orthopedic unit, and detailed discussions of the anatomy and physiology of joints. By Carroll B. Larson, M.D., F.A.C.S. and Marjorie L. Gould, R.N., B.S., M.S. May, 1978. Approx. 544 pp., 466 illus. **About \$15.70.**

New 7th Edition!

CARINI AND OWENS' NEUROLOGICAL AND NEUROSURGICAL NURSING. Reflecting a new emphasis on holistic care and its rationale, this comprehensive text reviews pertinent anatomy and physiology . . . explores various disorders of neurologic structures and functions . . . and integrates nursing care of special disorders with theories on pain, rehabilitation, and medications. Outstanding new chapters focus on embryology, neurologic assessment, sexual integrity, etc. By Barbara Lang Conway, R.N., M.S.; with 3 contributors. June, 1978. Approx. 656 pp., 307 illus. **About \$12.10.**

BEHAVIORAL SCIENCE

A New Book!

ALCOHOLISM: Development, Consequences and Interventions. How effectively can your students deal with alcoholic patients and their families? Reflecting a multidisciplinary approach, leading authorities in the field offer current perspectives on alcoholism and — developmental aspects, pathophysiological effects, problems in special groups, and therapeutic approaches. By Nada J. Estes, R.N., M.S. and M. Edith Heinemann, R.N., M.A.; with 27 contributors. July, 1977. 344 pp., 7 illus. Price, \$10.75.

New 3rd Edition!

CRISIS INTERVENTION: Theory and Methodology. This comprehensive text again provides a practical look at the theories and principles of crisis intervention. Outstanding new features include a noteworthy chapter on working with the chronic psychiatric patient on an out-patient, crisis-intervention basis, and timely discussions of rape, suicide, and old age. By Donna C. Aguilera, R.N., Ph.D., F.A.A.N. and Janice M. Messick, R.N., M.S., F.A.A.N.; with foreword by George Albee. January, 1978. 206 pp., 16 illus. Price, \$8.35.

CRITICAL CARE

New 2nd Edition!

EMERGENCY CARE: Assessment and Intervention. Stressing an interdisciplinary approach, leading authorities offer practical insights on the assessment and management of emergency situations. Students will benefit from timely new chapters on the role of the emergency department nurse, dental emergencies, sexual assault, child abuse, triage and assessment, and spinal cord injuries. Edited by Carmen Germaine Warner, R.N., P.H.N.; with 36 contributors. April, 1978. Approx. 560 pp., 36 illus. About \$15.70.

MATERNAL/CHILD

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PEDIATRIC NURSING: A Self-Study Guide. Using a case study format, this student-oriented workbook offers an effective method of reviewing the basic principles of normal growth/development, nursing roles, and pediatric illness. A student test, modeled on state board examinations, is a particularly helpful feature. By Norma J. Anderson, R.N., B.S. March, 1978. Approx. 240 pp., 20 illus. About \$8.95.

NUTRITION

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NUTRITION IN INFANCY AND CHILDHOOD. Fusing theory with clinical practice, this comprehensive text discusses the bases of nutrition, dietary intakes, and nutritional goals for children. Students will be particularly interested in timely discussions of behavior modification and drug therapies in nutritional problems, and the psychological/physiological background of obesity and anorexia nervosa. By Peggy L. Pipes, R.D., M.P.H. April, 1977. 218 pp., illustrated. Price, \$8.75.

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NUTRITION IN PREGNANCY AND LACTATION. How much do your students know about the "what and why" of effective nutritional counseling? This unique text integrates contemporary scientific theories with specific techniques needed for sound maternal/child nutritional therapies. Food patterns in various ethnic groups and the nutritional needs of the pregnant adolescent are just a few of the important topics discussed. By Bonnie S. Worthington, Ph.D.; Joyce Vermeersch, Dr.P.H.; and Sue Rodwell Williams, M.P.H., M.R.Ed., Ph.D.; with 3 contributors. July, 1977. 234 pp., 34 illus. Price, \$8.75.

COMMUNITY HEALTH

A New Book!

INNOVATIONS IN COMMUNITY HEALTH NURSING: Health Care Delivery in Shortage Areas. Emphasizing nursing's role, this dynamic collection of articles offers creative solutions to problems in areas where there is minimal or non-existent health care. An effective supplement for community health courses, it presents firsthand accounts of practitioners in these areas, and bridges the gap between "real" and "ideal". Edited by Anne R. Warner, B.A.; with 25 contributors. March, 1978. Approx. 192 pp., 23 illus. About \$8.35.

ISSUES, TRENDS AND ADMINISTRATION

A New Book!

NURSING RESEARCH: A Learning Guide. This useful text will help students identify basic concepts in nursing research . . . apply pertinent knowledge and skills . . . and use that knowledge to improve nursing practice. Student-oriented features include a list of selected readings, a glossary of terms and helpful discussion questions. By Natalie Pavlovich, R.N., Ph.D. January, 1978. 274 pp. Price, \$7.30.

New 2nd Edition!

THE GROUP APPROACH IN NURSING PRACTICE. Turn to this innovative text for sound information on the group process. Its four parts examine the scope of group work . . . outline various theoretical frameworks . . . discuss common objectives for group work . . . and focus on special techniques and considerations. A timely new chapter examines the process of establishing, maintaining and terminating a group. By Gwen D. Marram, R.N., B.S., M.S., Ph.D. January, 1978. Approx. 272 pp., illustrated. About \$8.35.

New 2nd Edition!

NURSING ADMINISTRATION IN THE HOSPITAL HEALTH CARE SYSTEM. Extensively revised and updated, this practical text offers an overview of nursing and explores current management theories, legislation and organizational controls. Students will be particularly interested in discussions of the role of effective communication systems in the decision-making process. By Edythe L. Alexander, R.N., B.S., M.A. April, 1978. Approx. 368 pp., 43 illus. About \$14.20.

For more information on these and other Mosby texts, write: The C. V. Mosby Company, Ltd., 86 Northline Road, Toronto, Ontario, M4B 3E5 A80293.

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■ Geriatrics

The Priory Method

The Priory Method is a 16mm color film of 20 minutes duration. It is a factual and spontaneous portrayal of normal human activities in a home-like, but modest long-term facility. The film reveals a psychosocial model in which the staff residents, families and volunteers use current theories, therapies and research in a modified and practical manner. The residents are viewed as the focus of a comprehensive medical, psychological and sociological program, which honors democratic and humanistic interaction. Residents are encouraged to be active physically, emotionally and intellectually by staff, who have been trained to project these characteristics themselves.

Philosophically, the Priory Method is a very simple application of the golden rule. Residents are photographed in various recreational, social and personal activities while pursuing interests or former lifestyles, in spite of handicaps. It is an excellent and timely educational tool for all health care providers, students and the public to show life can be rewarding to the end.

The film was made in 1970. It may be purchased for \$200.00. For information write: Mrs. Vera McIver, R.N., Director of Health Care, Juan de Fuca Hospitals, 567 Goldstream Avenue, Victoria, B.C. V9B 2W4.

Assessment of the Elderly Individual

The nursing department of Baycrest Hospital has developed a set of six videotapes on "Assessment of the Elderly Individual." The tapes are 3/4 inch for playback and cover the following subjects:

- Assessment of the Elderly Individual - Part I (8 minutes)
- Part II - Lifestyle (18 minutes)
- Part III - Organic Brain Syndrome (16 minutes)
- Part IV - Depression (20 minutes)
- Part V - Sensory Abilities (14 minutes)
- Interviewing a Patient - Simulation (60 minutes)

The tapes are based on information gathered at a workshop featuring Dr. Virginia Stone plus data gathered from Baycrest's own experience with elderly patients.

Baycrest Hospital has also developed a Rehabilitation Manual to teach specific procedures to nursing staff. The format of the manual is easy to follow.

Inservice educators will find the videotapes and manual helpful for their programs whether they are based in active treatment hospitals or institutions for long-term elderly patients or residents. For information contact: Marcia Dodick, Director of Nursing, Baycrest Hospital, 3560 Bathurst Street, Toronto, Ontario, M6A 2E1.

■ Death and Dying

Moments in Between

"Moments in Between" is a film produced by two young Montreal film-makers, Peter Byszewski and Morris Borenstein with support from the National Film Board. The film was made on a terminal illness ward of the Montreal General Hospital over a period of two years, and portrays what happens to dying people — how they learn to face, cope with and accept the realities of death and dying.

The film results were shared with patients, their families and hospital staff, and then they were edited, filmed again and re-edited until the present one-hour film emerged. Available from Canadian Filmmakers Distribution Centre, 406 Jarvis Street, Toronto, Ontario, M4Y 2G6.

A Time of Death

A 16-minute full color film with sound, designed for inservice education for nurses, social workers, paraprofessionals and other hospital staff; for orientation of staff in hospitals, nursing homes and other health facilities; for medical staff and education programs. The film depicts and describes affective problems of health care providers confronted by patient death. Statements of health care providers combine with documentary photography to help viewers confront their own death-related anxiety within the

constructive discussion-group context. Included with the film is a *Guide for Study and Discussion* to help direct discussion following the film. For additional information, contact: Focus International Inc., 505 West End Avenue, New York, N.Y. 10024.

■ Sex Education

The National Film Board and Health and Welfare Canada have produced three series of filmstrips on sexuality and human values — for young children, older children and young adults.

The filmstrips in each series are accompanied by a detailed set of Teachers' Notes containing filmstrip scripts, suggested ways to use the material and related activities. All 13 films have been developed in consultation with a variety of educators concerned with teaching human sexuality. They have also been shown and discussed with parents, teachers and school administrators.

A brief capsule of each series follows. Those wishing further information about any of the films may contact: Visual Education Centre, 75 Horner Avenue, Etobicoke, Ontario, M8Z 4X5. Residents of British Columbia, Alberta, Saskatchewan, Manitoba, the Northwest Territories and the Yukon write: Scholar's Choice Ltd. 1150 Homer Street, Vancouver, B.C. V6B 2X8.

• **Living and Growing** is a series of five color, sound filmstrips for children ages five to seven, and ages eight and nine. These filmstrips offer a new approach to the teaching of human values and sexuality for the very young. They deal with questions like — Where do plants, animals, and people come from and how do they grow? What is a family and how does one differ from another? What about friends? Loneliness?

"Living and Growing" uses artwork, whimsical story lines and a cast of beguiling characters to capture the imagination of pre-school and primary grade children. Songs, poetry, humor and games are designed to inform, involve, stimulate thought, discussion and related activities.

• **Facts and Feelings** is a series of five color filmstrips (three with sound) on values and human sexuality directed towards pre-adolescents and adolescents. The films include a study of peer group pressure, a captioned dictionary of sexual terms, a visual essay on human sexuality and a thought provoking enquiry into changing male/female roles. They are designed to make talking easier, to encourage children at this age to feel comfortable and responsible with themselves and their sexuality.

• **A Question of Values** is a series of three color sound filmstrips designed for those aged 16 and older. The films are intended to stimulate thought and discussion regarding values and social change, to evoke emotional and thoughtful response to these issues. The films hope to encourage further examination of the complexity and variety of social/sexual standards that today's young people may encounter.

Did you know ...

A new system which gives an immediate and reliable indication as to whether a patient with severe chest pains has suffered a heart attack has been developed by doctors in Stockholm.

The system will be an invaluable diagnostic aid to doctors, who have previously been hampered by the fact that an electrocardiograph is not always infallible, while a chemical enzyme test takes several days.

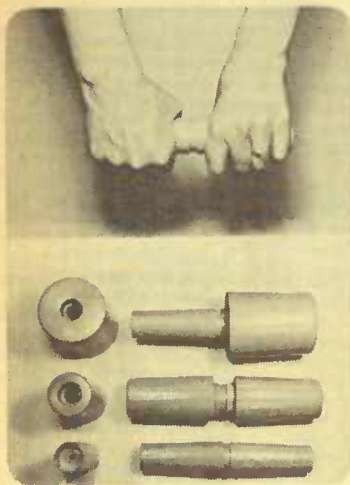
The new method provides for a strip of paper — treated in a manner not yet specified — to be dipped into a sample of the patient's urine. If he has had a heart attack the paper immediately changes color due to the presence of the pigment myoglobin (which is carried by the blood to the urine when the heart muscle is damaged).

The new paper strip test is said to have accurately identified 35 cases of heart attack out of a total of 36.

Information is supplied by the manufacturer; publication of this information does not constitute endorsement.

What's New

Exer-Twist Exerciser



The Exer-Twist Exerciser is designed for the grip, wrist, arm, chest and shoulders. Featuring adjustable resistance for progressive exercise, the exerciser provides much the same exercise as wringing out wet towels, (without the mess or inconvenience) to exercise the muscles of the hand, forearm (especially pronation and supination), arm and isometrically, the chest and shoulders.

Small enough to be taken anywhere, the Exer-Twist can be used as an integral part of therapeutic treatment, or for self-improvement exercises.

For further information, contact: Maddak Inc. Pequannock, New Jersey, 07440.

Infrared Heating Units

Argus International has developed a series of focused infrared heating devices for precision heating applications.

Concentrated energy heats only the precise area to be worked on, so energy is never wasted on surrounding space. Infrared heat does not contaminate, and is used for operations ranging from 50°C to 2200°C.

For information write: Argus International, P.O. Box 38, Hopewell, New Jersey 08525.

Normal Clinical Values

Roberts' Handbook of Normal Clinical Values, a new pocket-sized reference listing "normal" test values for a variety of clinical tests, is available from Science Editors, Inc.

The 62-page handbook, designed to fit conveniently into a shirt or lab-coat pocket, lists normal test values (along with variations under each appropriate norm to indicate the presence or absence of specific diseases) for blood, urine, cerebrospinal fluid, hormones, renal functions, and others.

Other special sections contain general information about cardiology, blood pressure, renal disease and pediatrics, as well as forensic data.

The handbook provides a readily-available and accurate reference guide to diagnostic test results.

The handbook is priced at \$6.95, with quantity discounts, from Science Editors, Inc., P.O. Box 7185, Louisville, KY 40207.

Choke and Survive

Choking is the sixth leading cause of accidental death in the United States. A new rescue technique has been instituted by the American Red Cross and a 15-minute self-teaching audiocassette and worksheet on this technique called "Choke and Survive" is available to help prevent death by choking.

A recent medical study shows that a victim's chances for survival are increased significantly when first aid is administered immediately. Waiting for the arrival of professional medical assistance is often too late, as death can occur within four minutes.

The small worksheet, which can be reproduced or reordered, pictures the "maneuver techniques" on the back and, upon completion, can be carried in purse or wallet as a handy reference.

For information write: Media Learning Systems Inc., P.O. Box 321, Fair Oaks, CA 95628.

ECG electrodes

A projecting tab has been incorporated into the design of foam-type disposable ECG electrodes manufactured by Graphic Controls Canada Limited. The tab facilitates speedier removal of the protective backing and contributes to easier handling of the electrode during application.

Graphic Controls has a full range of pre-gelled disposable electrodes in their Medi-Trace line, offering a choice of surgical tape or foam adhesive combined with standard or pure silver contact.

For further information contact: Paul Allore, Graphic Controls Canada Ltd., Gananoque, Ontario.



ECG Cables

The medical division of Graphic Controls has recently introduced Medi-Trace patient cables for ECG monitoring. Completely sheathed in white vinyl, components have been designed to provide increased flexibility, durability and safety.

Cables are available for most ECG monitors and feature a choice of either plastic coated snap or metal squeeze type tension clip for electrode attachment. Both types attach securely and allow the cable to rotate through 360 degrees while the electrode is in place. With each lead individually shielded, ambient interference is minimized to provide a "noise free" signal from the patient.

For information contact: Paul Allore, Graphic Controls Canada Ltd., Gananoque, Ontario.



Draining-Wound Management System

The Bottom-Drain Collector makes the Hollister Draining-Wound Management System a convenient time-saver. Like the regular collector, it collects exudate well away from the wound site. It is made of a special transparent film that provides a barrier against odors, fluids and microorganisms, making wound care safer and more pleasant.

The Bottom-Drain Collector is convenient, because it allows drainage into any standard bedside collection unit quickly and easily. Collector and Access Cap come in a sterile peel-pack for application in the O.R., I.C.U. or the patient's room.

For information, write: Hollister Limited, 322 Consumers Road, Willowdale, Ontario, M2J 1P8.

Good Toys

"Good toys" is a booklet that provides an analysis of more than 500 individual toys tested and approved by the Canadian Toy Testing Council. It is designed as a general guide to enable the consumer to choose wisely from among the many toys on the market.

The booklet gives parents the price range for toys as well as suitable age of the child. Testing is done by children in a variety of play environments — homes and schools. Each item listed in the booklet meets safety standards established for toys by the Hazardous Products (Toys) Act.

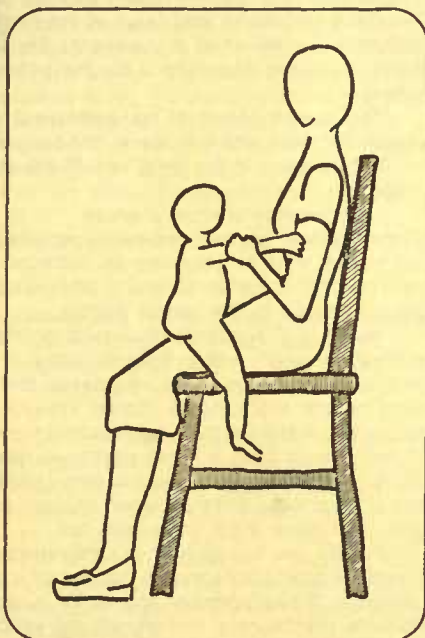
Good Toys is available for \$1.00 by writing to Canadian Toy Testing Council, P.O. Box 6014, Station J, Ottawa, Ontario, K2A 1T1.

Here's How



Every nurse has practical ideas gathered from his or her experience on how to make life a little easier for nurses and for patients. *Here's How* is a column for you and your ideas. If you have an original and practical suggestion that you think might help other nurses to improve any aspect of patient care, why not share it with other nurses? We'll send you \$10. for any suggestion published. Let's hear from you. Write: The Canadian Nurse, 50 The Driveway, Ottawa, Ontario, K2P 1E2.

I.M.s for Kiddles



Injections can be a frightening experience for a child. At Children's Hospital of Eastern Ontario, Day Care Surgery nurses use a method that makes I.M. injections easier for everyone, especially for the child.

The mother and child are told that the child is to receive an injection in the leg. The mother is asked to sit on an armless straightback chair. The child sits on his mother's lap, facing her, with his arms resting on his mother's arms. The mother holds the child by his elbows. While the mother and child are cuddling and talking, the nurse gives the injection in the anterior aspect of the child's thigh. If the child brings his arms down, they are blocked by the mother's arms. This approach seems to make the procedure less traumatic for both mother and child.

— Nancy Buckley Poichuk, Coordinator, Education and Child Study, Children's Hospital of Eastern Ontario, Ottawa, Ontario.

Easy Access

Too often, especially in older hospitals, supplies are kept too far away from some patients' rooms. If possible, keep enough daily ward supplies: meds, IVs, linen and paper supplies in a room close to the patients. Preferably, this room should be open on both sides for easy access.

If there is no such room available, time can be saved by keeping daily supplies on a movable cart. This arrangement is especially helpful when you are caring for patients who cannot be left alone, even for five minutes. Having supplies handy makes for better patient care.

— Aileen Haggart, R.N., Aylmer, Quebec. (Ottawa Civic Hospital, Ottawa, Ontario)

Regularity without Laxatives

On our orthopedic ward, we have found a good substitute for laxatives for keeping immobile patients comfortable and "regular." We find that two tablespoons of bran each morning with breakfast does the trick even more effectively than commonly prescribed laxatives.

— Evelyn Schaller, Head Nurse, Victoria General Hospital, Halifax, Nova Scotia.

Skin Care

Any long-term patient, or any patient who has to spend more than a week in the hospital, is prone to decubitus ulcers. We have found that half a cap of bath oil added to the daily bath helps to keep the patient's skin lubricated, and decreases the incidence of decubitus ulcers.

— Evelyn Schaller, Head Nurse, Victoria General Hospital, Halifax, Nova Scotia.

Information Visible

We take advantage of bulletin board space on our floor for teaching purposes, and we have found it to be beneficial to both patients and staff. Recently, we have had monthly exhibits on such topics as hypertension, diabetes and obesity.

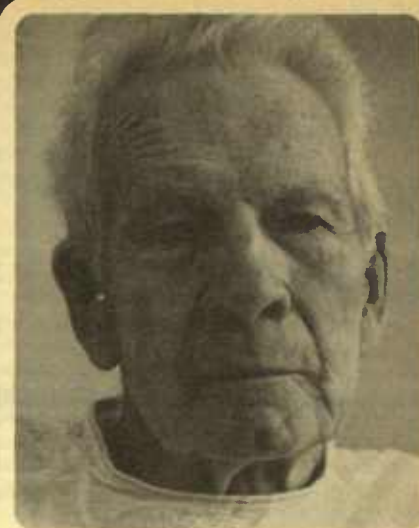
— Kathy Allen, Head Nurse, Victoria General Hospital, Halifax, Nova Scotia.

Dual Purpose

Here's a suggestion primarily for those who work in coronary care, although it could be used in many similar settings.

Paint routine physio exercises, like BREATHE DEEPLY FIVE TIMES AND THEN COUGH on the cardiac arrest board and hang the board where the patient can see it. This makes the board part of the furniture in the room, reinforces health teaching, and does not detract from its primary function.

— Judith A. Redman, Teacher, Staff Education, Vanier, Ontario.



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Books

Issues in Canadian Nursing by Betsy LaSor and M. Ruth Elliott, Scarborough, Ontario, Prentice Hall of Canada, 1977.

Canadian nurses will greet this publication with enthusiasm. Interesting papers, prepared especially for this book by eminently qualified Canadian nurses, provide information that is available in no other place.

The book is divided into three parts: Section I, Nursing Education and Practice; Section II, Nursing Practice; and Section III, Nursing in Legislation and Political Issues.

The first article is a clear and informative discourse on issues in nursing research centering around the "what" and "why" of it; where we are relative to development in other countries; funding; research roles and preparation for them. Anyone contemplating research as a career choice would find the discussion very helpful. The article concludes with a consideration of priorities. The novice may experience some difficulty in reading this part which appears to be addressed to a more sophisticated audience.

The second article has an *interprofessional* focus. Issues arise out of the discordance between technical nurse-doctor and expanded nurse roles. A number of programs featuring interdisciplinary undergraduate education are described.

The last article in Section I deals with an *intraprofessional* issue, the relationship between technical and professional education and practice. The viewpoint is refreshing.

Section II contains two articles. *Maintaining Competence: Realities and Myths* is a brief but thoughtful presentation of the problems that make continuing education a continuing issue. The companion article, more directly practice-oriented, first outlines variations in conceptualization and expectations of the clinical nurse specialist. Then it describes how the two authors worked through roles as clinical nurse specialists. Perhaps it is their insightful involvement, or maybe the use of the personal pronoun "we", but for some reason these authors "come alive." We actually see them at their work. Again, for those young nurses facing a career choice this article is a must.

The last three articles, comprising Section III, are educational for most of us and challenging for all. Written by nurses who have filled top echelon positions nationally or provincially they deal with federal and provincial government action in respect to health care; the organized profession and political action; and becoming essential partners in planning health care.

The book is well organized with helpful editorial comments. Questions are incorporated before and after each presentation. These will alert any reader to the issues involved and will be particularly helpful to teachers and students. With the exception of one article the documentation is

meticulous. It is to be hoped that the anticipated second volume will indeed materialize.

Reviewed by Lucy D. Willis, Professor, College of Nursing, University of Saskatchewan, Saskatoon, Saskatchewan.

Needs of the cancer patient by Joanne Parsons ed. Contemporary Pub. Inc. 1977. Approximate price \$5.95.

Needs of the cancer patient edited by Joanne Parsons, is the first issue of *Nursing Digest's* new format.

In the preface of the book, Parsons purports to address "the unique stresses imposed upon the person with cancer by his own and other's perceptions of cancer's meaning." Fourteen articles from such disparate sources as *The New York Times Magazine*, *The Canadian Nurse* and *The American Journal of Psychiatry* have been selected to meet this goal.

The comprehensive collection of articles expresses "the emotional and spiritual experience" of the patient with cancer. The impact of the disease on family members is addressed in some articles albeit tangentially.

A number of the articles are particularly noteworthy. Joanne Parsons' descriptive exploratory study of "Intermediate Stage Cancer Patients at Home" illuminates a scantily

researched area. She stresses the importance of this time period remarking that although most people currently die in hospital, months and weeks of dying occur at home. Her findings led her to conclude that people in this stage could most benefit from a "mutual help group" of cancer patients in the community with a nurse as an advisor. Although this approach merits investigation, the assumption that all such patients would benefit from and/or attend the support group is of questionable validity.

"The patient in pain — new concepts" by Benoliel and Crowley and "Use of the Brompton mixture ..." by Mount et al summarize the current theory regarding pain control for the cancer patient.

The special needs of the adolescent with cancer are discussed with clarity and compassion in "The symptom is the thing" by Plumb and Holland.

Unfortunately Madden's article "Rehabilitation" seemed somewhat out of place in this journal with its emphasis on technical skills such as post-operative care and ambulation that are not unique to the cancer patient.

Similarly, Comerford's discussion of "Parental anticipatory grief" written from a mother's perspective contains some information that is inappropriate according to current thought. For example, the child in the article learned the name of her disease from a friend yet her mother still urges caregivers not to use the term "leukemia" and siblings were told that "when children are too sick, God takes them to be with him."

Finally, the inclusion of a comprehensive annotated bibliography makes this journal a handy reference. It has potential appeal for nursing students, practitioners, researchers and educators.

Reviewed by Pat McKeever, School of Nursing, University of Manitoba, Winnipeg, Manitoba.

Alcoholism: development, consequences and interventions by Nada J. Estes and M. Edith Heinemann. 332 pages. St. Louis, Mosby, 1977.

Approximate price \$9.75 (paperback)

In my experience, this book is the best single-volume review of current information on our "Number One" nursing problem — the alcoholic person and his/her family. It is an outgrowth of an American baccalaureate course in Alcoholism Nursing. The content is equally applicable to Canadian nursing, and suggests to me that we could well place such emphasis on alcoholism nursing in our education system, at both a student and a staff-development level.

"*Alcoholism: Development, Consequences, Interventions*" is sufficiently up-to-date, clear in its

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writing style, and broad in scope to be a basic resource for students, for nurses in institutions or community agencies and to recommend to our non-nursing colleagues. The bibliographies attached to each chapter are recent and useful in themselves.

The book is divided into four sections. Part I deals with the epidemiological aspects of alcohol use, and Part II gives in considerable detail, the pathophysiological consequences to the patient/client of excessive alcohol use. Part III discusses the alcohol-related problems of special groups, and Part IV includes discussion of the traditional and newer therapeutic approaches to client and family.

The contributors have maintained a focus throughout on the family and social dimensions of alcoholism. Within this context, there are several topics of particular interest to me. The material on assessment of the alcoholic person, and the criteria for diagnosis is specific and universally useful. "Fetal Alcohol Syndrome" summarizes the information on the newly-recognized problem of the effects of alcohol on the fetuses of actively alcohol-abusive mothers.

"Alcoholism and the American Indian" offers as much insight as anything I have read into the problem of services to Indians in Canada. It offers suggestions for practical adaptations of alcoholism treatment programs which are more acceptable to and successful with Indian populations.

The final chapter on sobriety is one which I wish had been explored in greater depth. Maintaining sobriety is the "long haul" for patient, family, and worker. It is the struggle to re-make a disordered family around its newest member — the sober alcoholic. It is presented as the total-family experience that it truly is. I would welcome further discussion of the quality maintained in this excellent resource book.

Reviewed by Catherine Porter, Whitefish, Ontario.

Issues and crises during middlecence by Joanne Sabol Stevenson, New York, Appleton-Century-Crofts, 1977. Approximate price \$8.75

This book will be particularly welcomed by those who believe that the main emphasis in the health care delivery system must ultimately shift toward promotion of health.

This sociologically oriented text is written primarily for college students. It also has much to offer to any individual who is seeking to enlarge his understanding about the human odyssey of growth and development.

The contents reflect a clear straightforward approach to the subject matter. The manner of writing is conversationally smooth but it maintains the language and documentation of a scientific enquiry.

The author focuses on people between the ages of 30 and 70 years. Generally this group makes fewer demands on the services of a predominantly disease-oriented health system. They are considered to have achieved a mature adult status, are seen as being at the peak of their productivity, and performing key functions within most social institutions.

The study of human growth and development has produced a sizable body of literature that focuses on the young and the old. Comparatively little attention has been paid by researchers to adults in the middle years. Stevenson does not propose to deliver an exhaustive analysis of available writings and opinions about developments within the adult life span. Whenever attempts are made to discuss large complex

issues in a relatively small volume of writing the ever present danger of oversimplification emerges.

Repeatedly the author makes her awareness of this problem explicit and invites the reader to enrich his understanding through use of the extensive references and suggested readings provided at the end of each chapter. She openly admits to a "positive developmental bias about human adulthood." While not denying the "downhill approach" to the later stages in life that are reflected in much of the literature, the author clearly proclaims her belief in "positivity and the need to train oneself to view the world with a more positive orientation."

Each of the book's three parts starts with an overview. The content of the chapters is briefly discussed and relationships between individual issues are established. This not only enables the reader to enter more rapidly into a personal dialogue with the overall content, but it provides easier access to selective points under discussion. Value orientations are examined in a manner that invites further inquiry and provides both teacher

and student with an open forum for discussion. The first part of the book lays a historical and conceptual foundation for the examination of adult life phases. The chapter on systems theory with its focus on social systems, and the application of the concepts to middlecence is particularly noteworthy. The reader is challenged to consider the principle of equifinality with its implications for the process of scientific inquiry.

Throughout, the reader is presented with a sociological orientation that is congruent with the social systems theory. It culminates in a selected approach to role theory.

Part two deals with significant issues during the middle years. The discussion takes into consideration the traditional as well as the most contemporary developments in four major areas of life; work and leisure; family relationships; community responsibility-participation; and development of personal maturity. Some readers may find the approach to such topics as personal philosophy, spirituality, self-concept, and personal life goals somewhat confining. This is due largely



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to the vastness of the field. The author herself considers an exhaustive analysis beyond the scope of the book.

Part three presents the reader with a discussion of three adult life phases and its accompanying maturational and situational crises. The linking of specific age and maturation dependent phenomena to health-related crises is of particular interest to the nursing practitioner. Noteworthy is the section that deals with the concept of first and second order change developed by Watzlawick et al.

The first 150 pages of the book seem like a lengthy but necessary prologue to chapters eight and nine. The latter deal with the core of the middle years and its differential phases. One cannot help but wish that more space had been given to an in-depth discussion of the central theme of the book.

In the epilogue the author points toward the direction that needs to be taken to increase our understanding of the essence of development in the adult years. This includes a greater awareness of the potential for growth and recognition of the direction in which such growth takes place in adult life. Stevenson stresses the need for sociocultural accommodation to these changes by a more enlightened society. Individuals, the educational system, and particularly the health care professions are among those challenged by the author to reach out toward these new concepts in human development and to translate them into viable aspects of their personal and professional endeavor.

Reviewed by Irene E. Nordwich, R.N., M.Sc.N., assistant professor, School of Nursing, University of Manitoba, Winnipeg, Manitoba.

Library Update

Publications recently received in the Canadian Nurses Association Library are available *on loan* — with the exception of items marked **R** — to CNA members, schools of nursing, and other institutions. Items marked **R** include reference and archive material that does *not* go out on loan. Theses, also **R**, are on Reserve and go out on Interlibrary Loan only.

Requests for loans, maximum 3 at a time, should be made on a standard Interlibrary Loan form or by letter giving author, title and item number in this list.

If you wish to purchase a book, contact your local bookstore or the publisher.

Books and Documents

1. Annual register of grant support 1977-78. 11th ed. Chicago, Marquis Academic Media, 1977. 157p. **R**
2. *Association des traducteurs et interprètes de l'Ontario Annuaire*, 1976-1977. Ottawa, 1977. 55p. **R**
3. *Association of Translators and Interpreters of Ontario Directory*, 1976-1977. Ottawa, 1977. 55p. **R**

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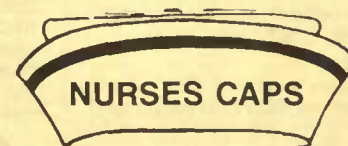
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Classified Advertisements

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Come to Texas — Baptist Hospital of Southeast Texas is a 400-bed growth oriented organization looking for a few good **R.N.'S**. We feel that we can offer you the challenge and opportunity to develop and continue your professional growth. We are located in Beaumont, a city of 150,000 with a small town atmosphere but the convenience of the large city. We're 30 minutes from the Gulf of Mexico and surrounded by beautiful trees and inland lakes. Baptist Hospital has a progress salary plan plus a liberal fringe package. We will provide your immigration paperwork cost plus airfare to relocate. For additional information, contact: Personnel Administration, Baptist Hospital of Southeast Texas, Inc., P.O. Drawer 1591, Beaumont, Texas 77704. **An affirmative action employer.**

Nurses for United States — Hospital openings for Registered Nurses and recent graduates for many cities in the U.S.A. Openings in all specialties—Critical Care, Operating Room, Recovery Room, Medical/Surgical, Emergency Room and Pediatrics. We will provide necessary work visa. No fee to applicant. For more information write to: **Medical Recruiters of America, Inc.** at one of the following addresses: 611 Ryan Plaza Drive, Suite 537, Arlington, Texas 76011; 500 So. Racine Street, Suite 312, Chicago, Illinois 60607; 800 N.W. 62nd Street, Suite 510, Ft. Lauderdale, Florida 33309; 5225 N. 19th Ave., Suite 212, Phoenix, Arizona 85015; 84 N.E. Loop 410, Suite 131E, San Antonio, Texas 78217.



N.B. ASSOCIATION OF REGISTERED NURSES

Nursing Consultant

To manage all matters pertaining to the practice of nursing which comes under the jurisdiction of the NBARN. The candidate will act in a consultative and advisory capacity to nurses employed in the health care delivery system in an effort to ensure quality nursing care for the people of New Brunswick.

Applicants must be eligible for registration in N.B. Preparation in nursing at the master's level. Bilingual (French and English) preferred. Minimum of five years related experience desirable.

Duties to commence June 1, 1978.

Send curriculum vitae and references by April 30 to Karon Croil, Executive Secretary, NBARN, 231 Saunders St., Fredericton, N.B. E3B 1N6.



N.B. ASSOCIATION OF REGISTERED NURSES

Educational Consultant

To manage all matters pertaining to nursing education which comes under the jurisdiction of the NBARN. The candidate will act in a consultative and advisory capacity to schools of nursing, as well as organize and develop continuing education programs for nurses.

Applicants must be eligible for registration in N.B. Preparation in education at the Master's level. Bilingual (French and English) preferred. Minimum of five years related experience desirable.

Duties to commence June 1, 1978.

Send curriculum vitae and references by April 30 to Karon Croil, Executive Secretary, NBARN, 231 Saunders St., Fredericton, N.B. E3B 1N6.

RED DEER COLLEGE requires

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Inquiries are invited concerning Nursing Faculty positions in a College based Diploma Nursing program. Sessional positions for the 1978 spring-summer terms, and regular positions for the next academic year may be available.

Applications should include a complete resume.

Address inquiries and applications to:

Dr. Gerald O. Kelly
Academic Dean
Red Deer College
Box 5005, Red Deer
Alberta, T4N 5H5

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University of Toronto
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M5S 1A1

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Apply sending resume to:

Director of Personnel
Stratford General Hospital
Stratford, Ontario
N5A 2Y6

The Registered Nurses Association of Nova Scotia invites applications for the position of REGISTRAR

The applicant should be a registered nurse with a strong background in nursing education.

Position is available June 1st, 1978.

Applications will be accepted until April 30, 1978.

For complete information,
including job description and
salary range, write to:

Executive Secretary
Registered Nurses Association
of Nova Scotia
6035 Coburg Road
Halifax, N.S. B3H 1Y8

The University of New Brunswick
invites applications and nominations
for the position of

DEAN OF NURSING

for a renewable term
commencing July 1, 1978

Applicants should have appropriate academic, administrative and clinical experience. Candidates should be conversant with higher education and the profession of Nursing in Canada. While a doctorate is desirable, a Master's degree, and eligibility for nursing registration in New Brunswick are essential. Applications should include a curriculum vitae and the names of three referees. The deadline for receipt of applications, whether direct or resulting from nominations, is March 15, 1978; submit these to:

The Chairman of the Search Committee for
Dean of Nursing

Dr. Mervyn Franklin
Vice-President (Academic)
University of New Brunswick
P.O. Box 4400
Fredericton, New Brunswick
E3B 5A3

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A Public Health Nurse is needed in the Southern Sudan to conduct refresher courses for nurses, assist in the training of Community Health Workers and conduct practical Maternal Child Health Clinics at the village level.

Experienced Nurses are also needed to teach student nurses in Ghana, Nigeria, Sierra Leone and Jamaica.

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For more information contact:

CUSO Health — 13
151 Slater Street
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K1P 5H5

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McMaster University School of Nursing in conjunction with the School of Medicine, offers a program for registered nurses employed in primary care settings who are willing to assume a redefined role in the primary health care delivery team.

Requirements Current Canadian Registration. Sponsorship from a medical co-practitioner. At least one year of work experience, preferably in primary care.

For further information write to:

Mona Callin, Director
Educational Program for Nurses
in Primary Care
Faculty of Health Sciences
McMaster University
Hamilton, Ontario L8S 4J9

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Address correspondence to:

The Canadian Nurse

50 The Driveway
Ottawa, Ontario
K2P 1E2



The University of British Columbia Dean of Applied Science

The University of British Columbia invites applications and nominations for the position of Dean of Applied Science. The Faculty of Applied Science includes the engineering disciplines, the School of Architecture and the School of Nursing. The present total undergraduate enrolment is 1916 students and the graduate program includes 210 students. The appointment as Dean could commence July 1, 1978 and could be for a period of up to 6 years, renewable by the Board of Governors on the advice of the President.

The successful candidate will be expected to provide strong academic leadership to a large and varied faculty which is active in research and which has a tradition of good teaching. Strong ties with the professional associations will be encouraged and contributions to University administration will be sought.

The position is open to highly qualified men and women. Experience with the Canadian academic scene is important. Salary is open to negotiation.

Applications and nominations should be sent before March 15, 1978 to:

President, D.T. Kenny
The University of British Columbia
Vancouver, British Columbia
V6T 1W5

and should include a comprehensive professional and academic resume and list of referees.



Nova Scotia Hospital Dartmouth, N.S.

Post Graduate Course in Psychiatric Nursing For Registered Nurses

Length of Course — 26 weeks
Commencement Date of next class — 2nd Monday in September

For further information, please write to:

Director of Nursing Education
Nova Scotia Hospital
Dartmouth, Nova Scotia
B2Y 3Z9

Extension Course in Nursing Unit Administration

Applications are invited for the extension course in Nursing Unit Administration, available to registered nurses and registered psychiatric nurses employed in full time management positions above the staff nurse level.

The program is designed to help the nurse in a management position update his or her management skills. The course comprises a seven month period of home study, introduced and followed by five-day intramural sessions. For the 1978-79 class the initial intramural sessions will be held regionally as follows:

Vancouver	August 21 — 25
Winnipeg	August 28 — September 1
St. John's (Nfld)	August 28 — September 1
Montreal (French)	August 28 — September 1
Hamilton	September 11 — 15
Ottawa	September 11 — 15
Toronto	September 18 — 22

Early application is advised. Applications will be accepted until May 15, 1978 if places are still available at that time. After acceptance, the tuition fee of \$275.00 is payable on or before July 1, 1978.

The program is sponsored by the Canadian Nurses Association and the Canadian Hospital Association and is provided in French and in English.

For additional information and application forms write to:

English Program	French Program
Director Extension Course in Nursing Unit Administration 410 Laurier Avenue West Suite 800 Ottawa, Ontario K1R 7T6	La coordonnatrice Cours d'extension en administration d'une unité de soins Faculté de Nursing Université de Montréal C.P. 6128 Montréal (Québec) H3C 3J7

Public Relations Officer

Responsibilities:

Provides information relating to association policies and activities through press releases and publications. Writes reports, newsletters and speeches for internal and external distribution. Assists in planning, coordinating and implementing information programs, including media relations. Provides administrative support to various sections within the association.

Requirements:

University diploma in journalism, public relations or other in the field of written communication.

A few years experience in writing and in media work, preferably in health field. Excellent ability to write and edit English or French, with speaking knowledge of the other language.

Salary: Negotiable

Apply to:

Director of Professional Services
Canadian Nurses Association
50 The Driveway
Ottawa, Ontario
K2P 1E2
(613) 237-2133

WANTED: R.N. with Baccalaureate of Masters Degree in Nursing

Assistant to the Director of Health Care Services is required immediately for a 320 bed long-term-care agency, with three 75-bed units under construction, situated in Victoria, B. C.

To assist in developing and guiding teams of personnel toward individualized, non-fragmented, restorative health care.

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Respond in writing to:

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The Priory
567 Goldstream Avenue
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V9B 2W4

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Apply to:

Mr. Lloyd Handrigan
Personnel Director
Curtis Memorial Hospital
St. Anthony, Newfoundland
A0K 4S0

I.C.U. NURSES

Several permanent positions will be available to commence April 1, 1978, on a new 31 bed Intensive Care Unit in Calgary's largest general hospital.

Applicants must be eligible for registration in Alberta. Preference will be given to individuals with experience in acute care nursing and/or advanced preparation.

Successful applicants will participate in a planned orientation.

Salary ranges from \$1059 — \$1265 per month plus education and shift premium. There is a comprehensive benefit package including denticare.

Please apply to:

Director of Personnel
Calgary General Hospital
841 Centre Avenue East
Calgary, Alberta T2E 0A1

Memorial University of Newfoundland

Faculty appointments are open in:

Primary Care Nursing — April 1, 1978

Maternal-Child Nursing (including
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Mental Health Nursing — September
1, 1978

Openings in other clinical areas.

Master's or Doctoral degree required.

Apply sending resume to:

Margaret D. McLean
Professor and Director
School of Nursing
Memorial University of Newfoundland
Box 259
St. John's, Newfoundland
A1C 5S7

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Assume responsibilities regarding organization of a Nursing Assistant Course to the James Bay Area natives.

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Hôpital Chashasipich
Fort-Georges, Baie James
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Telephone: (819) 981-2844

Port Saunders
Community Health Centre
requires

Registered Nurses

Applicants must be registered or eligible for registration with the Association of Registered Nurses of Newfoundland.

Positions available May 1978.

Salary is on the scale \$9,963. - \$12,282.

Living-in accommodation available for single applicants.

Applications should be addressed to:

Mrs. Madge Pike
Director of Nursing
Community Health Centre
Port Saunders, Newfoundland
A0K 4H0

Foothills Hospital, Calgary, Alberta

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A five month clinical and academic program offered by The Department of Nursing Service and The Division of Neurosurgery (Department of Surgery)

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Applications now being accepted

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Co-ordinator of In-service Education
Foothills Hospital
1403 29 St. N.W. Calgary, Alberta
T2N 2T9

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Intensive Care unit

A challenging nursing management position for our 13-bed Medical/Surgical and Cardiology Intensive Care unit of this active treatment teaching hospital.

The successful candidate will be a registered nurse and will have considerable clinical experience in medical/surgical and cardiology intensive care nursing; as well as a management background. Applicants will preferably have a Bachelor's degree in Nursing or Administration.

Interested candidates are asked to submit a comprehensive resume to:

Personnel Department
Misericordia Hospital
16940 — 87 Avenue
Edmonton, Alberta T5R 4H5

NORWAY

Kongsvinger Hospital

Registered Nurses

The new (1976) 233-bed county hospital in Kongsvinger is interested in applications from Registered Nurses (RNs).

Kongsvinger, a town of about 16,000 with a variety of small industries, is located about 90 km north east of Oslo and 30 km from the Swedish border.

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Salary scale: N.Kr. 52,161. — 70,399., depending upon experience and training.

More detailed information may be obtained by writing to: Sjeffssykepleier, Kongsvinger sjukehus, 2200 Kongsvinger, Norway. Applications will, however, be accepted *only* through the Canadian Nurses Association (as International Council of Nurses' "Nursing Abroad" programme participants).

Director of Nursing

Applications will be accepted for the position of Director of Nursing for a 177 bed accredited hospital, consisting of 41 active treatment beds at New Liskeard and 136 beds at Haileybury — 40 of which are extended care.

A new 136 bed facility has been planned with construction to commence in the spring of 1978 to replace existing hospitals and to serve the community of South Temiskaming population of more than 20,000.

The urban population represents close to 75% of the community and resides in the Tri-Town consisting of Haileybury, New Liskeard and Cobalt.

Good school, college and recreational facilities are available.

The position requires responsibility for the nursing administration of the Department of Nursing.

Qualifications:

M.H.A. or B Sc in Nursing is desirable. Applicants with several years experience at senior level and Nursing Unit Administration certificate or other combinations of experience and certificate programs will be considered.

Salary:

Commensurate with qualifications and experience.

Please apply with complete résumé to:

Charles P. Bowie
Administrator
Temiskaming Hospitals
Haileybury, Ontario
P0J 1K0

Vancouver General Hospital

requires

REGISTERED NURSES

Applications are invited from nurses interested in permanent or temporary employment with British Columbia's major teaching and referral hospital. Vacancies exist in both medical and surgical units as well as several specialty areas.

If you are interested in immediate or future vacancies or would just like to know more about nursing opportunities at Vancouver General Hospital, write to us. Please include information regarding your nursing experience and the areas and level of position in which you are interested.

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Contact:

Mrs. J. MacPhail
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VANCOUVER GENERAL HOSPITAL
855 West 12th Avenue
Vancouver, B.C. V5Z 1M9

Psychiatric Nursing Consultant

\$18,696 to \$22,452

This competition is open to both male and female applicants.

The Position: The incumbent will be responsible for the overall development and improvement of mental health and psychiatric nursing in New Brunswick. Work involves planning, organizing and delivering a program to ensure a high standard of nursing in mental health services. Principle duties include: advice, instruction and demonstration on quality care to nurses; functioning as a resource person for development of nurses in leadership and instructional positions; advice to nurses outside mental health services on the care of mental health patients; liaison with all organizations and agencies involved in psychiatric nursing care; and consulting in psychiatric nursing continuing education with the New Brunswick Association of Registered Nurses, nursing staff and nursing schools.

Qualifications: Candidates must be excellent practitioners in psychiatric nursing with teaching experience and be eligible for Registration as a Nurse in New Brunswick. They should have post graduate training in mental health and psychiatric nursing to the level of a Master's degree. Competence in English is essential; however, competence in both Official Languages is desirable.

Location: Department of Health
Fredericton

Competition Number NB 77-533

Apply:

New Brunswick Civil Service Commission
Room G-15, Centennial Building
P.O. Box 6000
Fredericton, New Brunswick
E3B 5H1

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Medical Services Branch
Department of National Health and Welfare
Ottawa, Ontario K1A 0L3

Name

Address

City Prov.



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 CONNAUGHT VACCINES

The Canadian Nurse

April 1978

The official journal of the Canadian Nurses Association published monthly in French and English editions.

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"One song leads to another, one friend to another friend" ... and there's more to any convention than speakers, debates and the election of officers. In Halifax in 1976, as this month's cover photo shows, there was sunshine, surf, lobster, and down east hospitality. We can't wish any more for those who are lucky enough to attend the 1978 CNA meeting in Toronto. (Photos by Wamboldt-Waterfield).

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses Association.

ISSN 0008-4581


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The Canadian Nurse welcomes suggestions for articles or unsolicited manuscripts. Authors may submit finished articles or a summary of the proposed content. Manuscripts should be typed double-space. Send original and carbon. All articles must be submitted for the exclusive use of *The Canadian Nurse*. A biographical statement and return address should accompany all manuscripts.

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 Canadian Nurses Association,
50 The Driveway, Ottawa, Canada,
K2P 1E2.

Nursing Digest presents a conference on the

ALL-RN Nursing Staff

Chaired by **Genrose Alfano, R.N., M.S.**
and featuring **Barbara Brown, R.N., Ed.D.**
Luther Christman, R.N., Ph.D.

and five other experienced, knowledgeable workshop leaders at the **DRAKE HOTEL** in Chicago on July 26-28, 1978

Registration Limited to 600 . . . on first come, first served basis

Application Pending for Continuing Education Accreditation

The all-RN nursing staff concept generates comment on all levels for it affects structure as well as staff. Considerations range from cost and staff availability to departmental organization and interdisciplinary relationships. Most of these issues have not been addressed systematically until now. In a two and one-half day conference, you, Genrose Alfano and the other conference faculty will work together on the knotty problem of all-RN staffing.

The program objectives are:

1. To examine the feasibility of the all-RN staff;
2. To identify the problems in implementation;
3. To develop strategies for overcoming the problems.

Major questions such as accountability . . . nursing department organization . . . cost . . . levels of staff performance . . . availability of qualified nurses . . . nursing care quality . . . effect on physicians and other health workers . . . and more, will be addressed.

The opening session will feature:

- THE ADVANTAGES OF THE ALL-RN NURSING STAFF, Alfano
- EXPERIENCES IN SETTING UP AN ALL-RN NURSING STAFF, Brown
- ACCOUNTABILITY WITH AN ALL-RN NURSING STAFF, Christman

During both afternoons, you will participate in one of eight issue-focused workshops designed to explore feasibility and operational issues and to develop problem-solving strategies. The second and third mornings will be general sessions in which the eight workshop leaders report on the results of their activities the previous afternoon. The last morning session will be open-ended to accommodate additional comment, controversy and concluding remarks.

Is the all-RN staff the wave of the future? It should be quite clear by the end of this conference.

CALL FOR PAPERS

Ms. Alfano welcomes communication with anyone who has experience with all-RN staffing. She would also like to receive papers related to the concept. All communications and papers should be directed by May 1, 1978, to Genrose Alfano, c/o Carol Wolfe, Nursing Digest, Inc., 12 Lakeside Park, Wakefield, MA 01880

The proceedings of this conference, and other papers will be published in 1979 by Nursing Digest, Inc.

Audio tapes of this conference will be available for sale.

REGISTRATION FORM

Return to: Ruby Browne
The All-RN Conference
Nursing Digest, Inc.
12 Lakeside Park
Wakefield, MA 01880

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Perspective

Herein

Guest editorial

Collaboration, not competition

Have you been wondering: What is a Nurse Practitioner? Is there a Nurse Practitioner role? What differentiates the work, activities, and functions of a Nurse Practitioner from the nurse? How is the Nurse Practitioner educated? Why did this special category of nurse emerge?

Answers to these questions are both inconclusive and controversial. That's why this edition of *The Canadian Nurse* is of special significance to the nurses of Canada.

My own review of the literature suggests that there is not one nurse practitioner role, but several. It also reveals that the nature of these roles is largely a function of a process of negotiation between physicians and nurses. This type of relationship is not new. What do we know about this process?

It has been found that areas of motivation and commitment differ greatly among individuals in an interdisciplinary group. Professionals are undoubtedly trying to achieve different ends. For example, the nature of health care itself is usually perceived differently by medical, nursing and other health professionals. Rather than capitalizing on these differences, for they are potential strengths in the system, there has been a tendency to cloud the dividing lines between professions with ambiguity.

Some physicians and nurses have worked together to develop measures which allow nurses to perform medical tasks with an efficiency and skill equal to that of physicians. This has helped to move nursing toward a broader role. It has provided medical services where none existed and may have helped to reduce costs. Nevertheless, its consequence has been to reinforce the present model of care without making an apparent impact upon the overall health of Canadians.

I believe we are now ready to take the next fateful step. Which way shall we go?

Physicians and nurses can make different, but complementary, contributions to the provision of health care. With a little initiative, we can identify broad functions for each profession, some shared and some individual or unique, and help to close the gaps that exist in our services. But the knowledge and skill which each of us brings to the provision of health care of outstanding quality will require articulation. It will be difficult for both professions to understand the nature of ideal complementarity since, through the popular avenues of compromise and consensus among groups, there is always more strength in one position than in another. We must develop new mechanisms in our relationship based upon collaboration rather than upon competition.

For years now, we have talked about teaching nurses to become members of an interdisciplinary team. But, since nursing has always believed that a scholarly and committed approach to the study of primary care can result in an increased knowledge of health itself as well as clearer ideas of how individual and family health may be generated and maintained, should we not direct more of our efforts and expertise to this end? The title, Nurse Practitioner, may soon be an anachronism. But the objective of identifying what each profession, working in cooperation with others, can deliver while still maintaining its own professional integrity, is only beginning to be realized.

Joan Gilchrist



What is a nurse practitioner? Where does she work and what does she do? And what role does she have in Canada's health care scheme, present and future? This month, CNJ tries to answer these questions in a three-part feature article on the nurse practitioner. **Bonnie Maloney** (above) a nurse practitioner in a busy Ottawa clinic tells us what her role means in day to day terms; spokesmen from nursing education, public health and provincial nursing associations from Canada's ten provinces give us a national picture; and **Dorothy Kergin** and **Mona Callin** of McMaster University give us an idea of what the future holds for the nurse practitioner.

This April issue is your "convention issue." In it you'll find a detailed program for the four days of the convention and information on the 27 nurses who are running for elected office for this biennium. Putting the whole thing in focus, is a word of explanation from CNA president Joan Gilchrist on how your association operates, the people who direct it and how they are elected to office.

Next month, CNJ takes a look at two different settings, one in Montreal and one in Fredericton, where **primary nursing** has been put into practice. Head nurse and author, **Marlene Medaglia**, explains how primary nurses working in the Coronary Care Unit of the Montreal General are able to give more comprehensive care to patients and Gail Storr tells us how primary nurses on the maternity unit at the Dr. Everett Chalmers Hospital take the time for a thorough postpartal assessment of new mothers.

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Input

What's for dinner?

While there were many helpful suggestions in the article "Infancy: The Neglected Age in Nutrition Education" by Carol Sage, I was dismayed by the Suggested Guide for the Introduction of Solid Foods, Table 1.

In March 1977 I attended a televised symposium in Toronto on the topic of infant nutrition. It presented the opinions of pediatricians across America and was televised simultaneously in 23 U.S. and Canadian cities.

The main conclusion was that human milk was the only food necessary for the first six months, or, in its absence, prepared formula with partially denatured protein. Solid foods were recommended beginning with rice cereal at about six months, but human milk or formula was still recommended as the main source of nutrition for the second six months.

The reasons for not giving solids before six months are the potential for food allergy and obesity as well as sodium excess and increased renal solute load. It was stated that a six month old on 2% milk and solids three times a day (the usual routine) receives 600% of his daily sodium needs. Even whole cow's milk is not recommended until one year, for the same reasons.

The reasons the author gives for starting solids earlier are the same old pitches given by the commercial baby food companies which bring us spaghetti and bacon flavored baby dinners i.e. to introduce flavors and get baby used to eating early in his first year, and to encourage rapid growth.

The chairman of the Committee on Nutrition of the American Academy of Pediatrics, has outlined the following schedule of infant feeding in the July 1977 Dialogue on Infant Nutrition (a continuing series of papers resulting from the many questions asked by doctors in the 23 cities):
1 to 6 months — breast milk or formula
6 to 7 months — add rice cereal
7 to 8 months — add applesauce one week, pears one week, peaches one week, any of above one week.
8 to 9 months — add carrots, squash, beans and peas, one week at a time, if tolerated.

9 to 10 months — add beef one week, lamb one week, and use both the last two weeks

10 to 12 months — add cottage cheese and toast

1 year — switch to whole cow's milk, limited to 1 to 1 1/2 pints a day.

Every addition is for nutritional reasons or for the avoidance of allergy, not to increase tolerance of strong tastes or to encourage chewing, or for "independence."

I think all babies will eventually chew, insist on feeding themselves, and eat solids if their milk intake is kept to a reasonably low caloric level. There is no need to push them to develop in these ways at the risk of overloading the kidneys, increasing the number of fat cells, causing food allergies, and possibly even contributing to cholesterol problems later in life.

— Anna G. Scott, B.Sc.N. (Public Health Nurse) Williamsford, Ont.

Timely intervention

I am writing in regard to the federal banning of mechanical devices used for propping infant feeding bottles. I would like to commend the Canadian Nurses Association and the Manitoba Association of Registered Nurses for their intervention and recommendation which led to this action.

It is true that bottle propping can result in regurgitation and aspiration of food; it can also lead to chronic otitis media. Milk, an excellent media for bacteria, can pool in the mouth of an infant lying flat and travel to the eustachian tubes which lie between the pharynx and the middle ear. I wonder how many infants have lost some degree of hearing acuity due to this practice.

As health professionals and client advocates, we need to continue to intervene on behalf of ourselves and our clients. By our continuing participation in health care issues, can we as nurses, upgrade our position to become an independent profession, rather than "doctor's helper" as so many view us to be?

— Magda Schijff, R.N. Ont.
Reg. 74-1240 6, Durham, North Carolina.

Anti-smoking group formed

This letter is to inform your readers of a newly formed group of citizens who share a concern about the increased use of cigarettes by young females. The aim of the group, named SALUS, is to convince young girls not to smoke. The emphasis is put on young girls because they have shown the greatest increase in smoking of any age group. We feel that there are some steps that could be taken by the public to promote this cause.

One is to persuade the government to alter the warning on cigarette advertisements and packages. At present, it reads: *Warning. Health and Welfare Canada advises that danger to health increases with amounts smoked — avoid inhaling.*

On some packages, the print is so small as to be almost unreadable. The wording has little impact; it is not a specific statement or a definite prognosis. Moreover, the inclusion of the words "avoid inhaling" implies that the first part of the warning is going to be ignored by many smokers.

An alternative message could state:

Cigarette smoke contains carcinogens that cause carcinoma and increase mortality from cancer of the lung as much as five-fold and risk of heart attack, four-fold.

The second method is for hospitals to prohibit smoking by visitors anywhere on hospital property. Such a prohibition would serve as a direct warning from an official medical authority.

— Eric Curwain, secretary of SALUS, Toronto, Ont.

Maritime view

We are pleased that our Quality Assurance program made the "News" in the February issue of CNJ.

We are, however, somewhat surprised by the headline on the story — "Quality Assurance comes to Nova Scotia" — which rather implies that quality assurance is a new thing in these parts.

In fact, the nurses of Nova Scotia, over a period of many years, and working through their professional association, have

directed much attention to improving nursing standards throughout the province.

More recently, (1973) the RNANS Executive set up a special committee widely representative of all areas of nursing practice and education, which worked for two years on behalf of the membership, to prepare "A Framework for the Practice of Nursing in Nova Scotia — Guidelines and Standards." This document was published early in 1976.

The nurses of Nova Scotia have always striven for high standards of nursing practice and are presently involved in finding new approaches to planning and implementing patient care, in line with current thinking on consumers' rights and the accountability of professionals. Dorothy Miller, Public Relations Officer, RNANS.

Editor's note: Having talked with RNANS nursing service consultant, Jean MacLean, during the first national meeting on standards of nursing practice hosted by MARN in Winnipeg last November, and having been impressed by her account of the work in progress there, I can assure the nurses of Nova Scotia that no editorial comment was intended in that particular headline. Signed: Foot-in-mouth.

Health Happenings

Continuous ambulatory peritoneal dialysis (CAPD) may become a reality for some patients. Dr. W. Moncrief reported to the American Society of Nephrology that CAPD employs the continuous presence of peritoneal dialysis solution in the peritoneal cavity, 24 hours a day, 7 days a week except for the periods of drainage and instillation of two liters of fresh dialysis fluid five times each day.

With this technique, weekly clearances of large solutes are almost ten times greater than with current hemodialysis techniques and clearances of small solutes are comparatively the same.

So far, nine patients in the United States have used the CAPD method.

News



Members of the Steering Committee for the Development of National Standards of Nursing Practice, pictured during their recent meeting are: left to right (above) Myrtle Tregunna, Betty Sellers (who replaced Barbara Boyle at this meeting); Mary Robinson; Susan Smith and Deidre Blank; (top right) Jackie Steward; Jean MacLean, Clarrie Case and Sharon Crozier.

Committee members were welcomed to the meeting by CNA executive director, Dr. Helen K. Mussallem and Dr. D.D. Gellman, (far right) director general of the Health Standards Directorate, Health and Welfare, Canada, seen here with project director, Norah O'Leary.



Standards of nursing practice committee holds first meeting

Fourteen nurses from every Canadian province and territory, along with two representatives from provincial directors of public health nursing and provincial government nursing consultants were in Ottawa in mid-February to attend the first meeting of the Steering Committee for the Development of National Standards of Nursing Practice.

The group identified three objectives for the project:

- development of a national definition of nursing practice
- development of national guidelines or standards of nursing practice that are (a) general in nature and applicable to all areas of practice (b) appropriate for designated specialty areas.
- publication of the definition of practice and guidelines for standards of nursing practice.

Guest speaker at the meeting was Irma Lou Hirsh, coordinator, Implementation of Standards for the American Nurses Association. The

ANA standards were published in 1973 and are now being implemented at the local level.

Members of the steering committee and the areas they represent are: Margaret Barker, Yukon; Deidre Blank, Manitoba; Barbara Boyle, Alberta; Thelma Cameron, provincial government nursing consultants; Clarrie Case, Newfoundland; Syaron Crozier, Northwest Territories; Nicole Du Mouchel, Quebec; Marjorie Hewitt, Saskatchewan; Janet Kennedy, provincial directors of public health nursing; Jean MacLean, Nova Scotia; Mary Robinson, Prince Edward Island; Susan Smith, Ontario; Jackie Steward, New Brunswick; Myrtle Tregunna, British Columbia. The next meeting of the Steering Committee is scheduled for July.

Nurse practitioners examine ongoing education needs

Over 100 nurse practitioners met in Toronto March 9 and 10 for the fourth Annual Workshop of the Nurse Practitioners Association of Ontario. Although most registrants were from southern Ontario, the well-organized meeting attracted NPs from northern Ontario, Manitoba, Alberta, Quebec and Newfoundland. Suzanne Finnie, president of the 127-member association and a nurse practitioner at Flemingdon Clinic in Toronto, welcomed the enthusiastic audience.

The meeting focused on the ongoing education needs of nurse practitioners. Physicians, all specialists in their fields, held seminars on sports injuries, eye problems, rashes, adolescent problems, breast cancer detection and the "how to's" of article writing. Problem-solving seminars and discussions were conducted by nurse practitioners on a variety of topics:

- Babs Malone and Paula Salada, both from the Sioux Lookout Zone, discussed chest pain while Johanna

Rousseau, Dorothy Ann Mills and Tish Butson from McMaster talked about urinary tract complaints;

- Shirley Wheatley from the Family Planning Clinic discussed values and sexuality and Sharon Ridgely discussed the alternatives to unplanned pregnancy;

- Shirley Wilcox and Bernice King along with a nutritionist participated in a panel discussion on diabetes.

The newly elected executive of the association for 1978-1979 included:

president: Suzanne Finnie;
past president: Susan Levesque;
vice-president: Ruth Nodtvedt;
secretary: Heather Moeser;
treasurer: Isabel Vanderlist
councillors: Felicity Duncan, Shirley Wheatley, Johanna Mousseau, Diana Vanderpryt, Marsha Frank, Elaine Campbell, Jan Zendegs.

For more information about the Nurse Practitioners Association of Ontario, see page 20 of this issue of CNJ.

News

University of Western Ontario hosts annual CUNSA conference

Marjorie Bogaert

Nearly 600 student nurses from 24 university schools of nursing across Canada attended the annual CUNSA conference held this year at the University of Western Ontario, in London from February 2-5.

The Canadian University Nursing Students Association (CUNSA) is the only organization for university nursing students in Canada. The annual conference is a vehicle for promoting and stimulating student interest and participation in nursing issues and activities. The

educational, business, and social events are all geared to giving CUNSA members an opportunity to share their ideas, feelings, and enthusiasm about the nursing profession. It provides the student with information and news about nursing at other universities, at regional, national and international levels.

The delegates were welcomed by Dr. D. Bocking, vice-president of health sciences, University of Western Ontario; Jean Forrest, basic coordinator, faculty of nursing, U.W.O.; and Nancy Hickman, president of the Nursing Students' Council, U.W.O.

All events at the conference were based on the theme:

"Nursing Change: Active or Passive." The keynote address "Change: To What Extent Have We (Nursing) Been Innovators?" was given by Dr. M. Josephine Flaherty, principal nursing officer for Canada. Other guest speakers included: Irmajean Bajnok, president of RNAO; Jessie Mantle, professor, U.W.O.; Jocelyn Hezekiah, director of nursing programs, Humber College, Toronto; and Pat Olien, P.H.N., alderwoman, city of London.

Some of the other activities for the weekend included tours of London's University Hospital, fitness testing and a variety of sports and evening social activities.

Business and regional meetings were held on Friday and Saturday mornings. The past national research coordinator Mary Comer, (Mount St. Vincent University, Halifax, N.S.) and the past national chairperson Peggy Wareham (Memorial University, St. John's, Nfld.) gave a presentation on the ICN conference they attended last May.

Elections for the 1978-1979 national executive took place on Saturday afternoon. The national executive includes: Marjorie Bogaert, national chairperson, U.W.O., London, Ontario; Anna Gerrisser, national research coordinator, University of Toronto, Ontario; Terry Jackson, Western regional chairperson, University of British Columbia; Cindy Barrett, Ontario regional chairperson, Lakehead University; Carol Werner, Quebec regional chairperson, McGill University; Colleen Power, Atlantic regional chairperson, Memorial University. The regional research coordinators were also elected at this time. Next year, the national conference will be held at the Université de Moncton, Moncton, N.B.

Canadian Council on Hospital Accreditation (CCHA). Granted in mid-February, the VGH accreditation carries an important stipulation: CCHA requires a one-year interim report on progress toward improving conditions at the hospital.

The hospital's accreditation status and expectations were in question in part because of action taken by the Registered Nurses Association of British Columbia. The hospital was inspected by CCHA in October 1977, but complaints lodged by RNABC in December spurred CCHA's second visit to VGH in January, 1978.

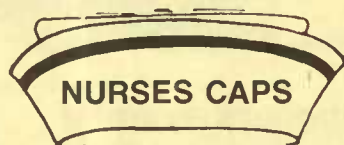
RNABC's involvement began late last summer, when the association received numerous unsolicited complaints from VGH nurses and others. RNABC asked for documentation of any unsafe conditions and received descriptions of some 60 incidents during a two-month period ending in mid-November.

The documentation collected by RNABC members pinpointed three major areas of concern: "inadequate numbers of staff," "inappropriate staff allocation resulting in lack of continuity of care and unsafe conditions," and "the apparent inability of the nursing leaders in the agency to take appropriate action in solving problems." These same incidents were reported simultaneously through hospital channels with no results.

RNABC's reps met with Health Minister Bob McClelland, and VGH trustees. The association also placed its documentation at the disposal of CCHA. Steps taken by the hospital to improve the situation included the allocation of \$100,000 for nursing relief and float staff through March 1978 and a reorganization of the hospital's nursing department.

CCHA executive director A.L. Swanson said that requiring VGH to make an interim report helps to assure follow-up of the issues raised by RNABC. RNABC president Sue Rothwell says that she is quite satisfied that VGH received accreditation, as it indicates that steps have been taken towards improving care.

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News

Drug information needed by elderly

The need for education of the public on the use of non-prescription drugs was stressed during a two-day "Symposium on Self Care" sponsored by the Proprietary Association of Canada, the manufacturers of non-prescription medicines.

Held in Ottawa on February 22-23, the symposium attracted educators, pharmacists, doctors, nurses and a large number of representatives from drug manufacturing firms and government agencies.

Robert Luke, president-elect of the Canadian Pharmaceutical Association told the more than 150 delegates that the pharmacist is trying to change his image from drug dispenser to drug information dispenser. One way to enhance public education, he said, was by the use of "patient package inserts". All drugs that need an insert, including many over-the-counter drugs would be handled by the pharmacist so that contraindications, side effects etc. could be explained to the client by the pharmacist. Luke explained that so far, the idea of a drug information insert is just in the talking stage.

Luke added that with the volume of non-prescription drugs now on the market, a Proprietary Medicines Publications similar to the Canadian Pharmaceutical Specialties (CPS) for prescription drugs will soon be available in Canada.

Heather Clarke, assistant professor of nursing at the University of Victoria in Victoria, B.C., pointed out that the elderly are an "at risk" group concerning self-medication. She said that a 1976 study on the elderly and drug education carried out by the Social Planning and Review Council of British Columbia found that gaps in the communication between the pharmacists, physicians and their patients, along with improper methods of drug self-administration are significant factors in drug misuse.

In British Columbia, persons over 65 used an average of 13.5 prescriptions in 1976. This is a 30 percent increase since 1974 when

the average was only 10.8, she said.

"Studies of the use patterns of drugs show trends to self-medication, loaning and borrowing prescription drugs and saving medicines no longer being taken. Lack of practical information or instruction on appropriate use often leads to unwise actions including overdose, omission, duplication and inappropriate use of as "required medication" she said.

Clarke stated that nurses, especially community health nurses should be educating and motivating elders in health self-care. She added that self-medication was only a small part of the total concept of health care.

A panel of physicians generally favored self-medication with over-the-counter drugs for "trivial" or self-limiting conditions.

BC nurses support joint conference committee

The B.C. government will act to promote greater nursing involvement in hospital policy-making at the local level, B.C. Health Minister Bob McClelland told a delegation from the Registered Nurses Association of British Columbia meeting with him in mid-January.

Association representatives have been seeking a change in the model by-laws provided by the government to all hospital boards. McClelland promised to change the model by-laws to allow nurses greater access to hospital boards of trustees.

The existing by-laws call for advisory committees to boards of trustees consisting of equal numbers of physicians and administrative staff. RNABC is seeking to replace these advisory committees with joint conference committees that include nursing staff representation.

Present at the meeting with McClelland were RNABC president Sue Rothwell, vice-president Stephany Grasset, directors-at-large Barbara Burke and Shelly Kremer, executive director Nan Kennedy and employment referral director Marilyn Carmack.

NS supervisors hold second meeting

The Second Conference of Evening and Night Supervisors held in Sydney in February, marked the formal organization of the group as the "Evening and Night Supervisory Group, Cape Breton County."

The goals of the group were determined as follows:

- improving quality of care;
- determining common approaches to problems;
- improving communication among supervisors, directors, physicians, administrators;
- improving job satisfaction for evening and night staff.

Dixie Smith, who is a night supervisor at the Nova Scotia Rehabilitation Centre in Halifax as well as a practising lawyer, talked to the group about the legal aspects of their responsibilities.

Another item on the agenda was the response of the Directors of Nursing to the Position Paper presented to them by the Supervisors after their initial meeting. The position paper stated the beliefs of the supervisors:

- that needed changes could be made if hospital boards, administrators, directors of nursing and physicians work with them collectively and in individual hospitals, using a problem-solving approach;
- that much progress could be made through the establishment of clear written policies. It also emphasized the policies which should receive high priority, such as criteria for use of Emergency/OPD after hours, coverage for absent staff, etc., and stated that much benefit would result if the group could meet three times a year.

Gladys Smith, director of nursing at the Glace Bay General, and President of the RNANS, gave the response of the Directors. They were positive in their support of the supervisors, in their recognition of the problems and the need to develop policies and in their promise to pursue realistic approaches.

Officers and hospital representatives elected were: chairman, Kay McGuire, St. Rita; secretary, Frances MacCormack, Northside General; treasurer, Laura

MacKinnon, New Waterford Consolidated; and Kay MacInnis, Glace Bay General; Dolores O'Neill, St. Joseph's; Lilian Hearn, Sydney City; Rose Marina Brown, Cape Breton Hospital; Joan Young, Harbour View, Jean MacLean, RNANS Nursing Service Consultant, coordinated the conference and acted as chairman until the newly elected chairman took over.

Evening and night supervisors in other regions of Nova Scotia are also planning conferences. Dates have been set for the Halifax-Dartmouth area for April when eleven hospitals will participate, and in May for the Northern region with participation of sixteen hospitals expected.

It is hoped that a provincial meeting with representation from all areas will be held later in the year.

Infection control group started

A meeting in October, 1977 marked the founding of the Newfoundland Infection Control Association. The group will meet quarterly to discuss infection problems in hospitals and promote uniform policies and practices in the common aim of infection control. Officers elected for the group are: president — L. Case of the General Hospital in St. John's; vice-president — A. Bell of Western Memorial Hospital in Corner Brook; and secretary — Elizabeth Mercer, of the Salvation Army Grace General Hospital in St. John's, Newfoundland.

Employment service for nurses

The New Brunswick Association of Registered Nurses is laying the foundations for an employment service for nurses across the province.

The services provided are to be similar to a Manpower Centre enabling:

- any person, agency or institution requiring the services of a nurse to benefit from the central service;
- any nurse seeking employment to look at the range of positions available across the province.



The patient's choice vs. the nurse's judgment

Corinne Sklar

Your patient, Peter, is a 32-year-old man with cancer of the testicle. He has had surgery which has removed some of the malignancy. Peter knows his prognosis; he has read extensively about his illness and its treatment. Now in the final stages of his illness, he is in hospital receiving the usual combination of chemotherapy and radiotherapy.

The doctor has ordered both Demerol and morphine p.r.n. for relief of the patient's pain; the choice of drug is up to the nurse. Peter is "afraid" of morphine and doesn't want it, he wants to be "conscious of things when he's going" and to be aware of events and people around him.

Peter has told you and others that his doctor has agreed with Peter's request to have "control over his treatments" and that Peter "won't have to do anything against his will." Peter believes that although morphine is ordered, it will only be given if he (Peter) thinks he needs it.

WHAT WOULD YOU DO?

Peter requires medication for pain. In your judgment, morphine is indicated. You prepare it and take it to Peter's bedside. Peter asks: "What are you giving me?"

WHAT DO YOU TELL HIM?

WHAT DO YOU DO?

The foregoing problem was taken from a real-life situation submitted to *The Canadian Nurse* by a reader. Peter (not his real name) was her friend. What happened in his case was reported to her by others. As a nurse, she was concerned about what had followed:

Peter had asked the name of the medication he was to receive. The nurse told him it was Demerol. The nurse had later explained to the patient's wife that in fact it was morphine and not Demerol that Peter had been given. The nurse further explained that she felt that Peter had needed the morphine.

Peter's friend did not see him alive again. She was left with a feeling that Peter had been "let-down" yet the doctor's orders had clearly stated Demerol or morphine.

The patient stated a choice; the nurse followed her judgment: Was there a "right" course of action in this situation? If so, what was it? Was anyone to blame for what happened?

Opinion

This reader raises some very important questions.

- Certainly a patient does have the right to decide what shall be done with his body, a right that is protected by law and enshrined in the doctrine of informed consent. He can refuse to consent to treatment. He can prohibit a certain form of treatment. If this refusal does not conflict with the professional judgment of those who are responsible for his care, there is no problem. But when conflict arises, as it did in the case of Peter, how far does the patient's right to choose go? Can he dictate medical and nursing choices regarding his treatment? How much control does he have over the care he receives? When do medical and nursing judgments take precedence over his stated preference?

Peter, for example, was in the terminal stages of his illness. He was afraid of morphine; he wanted to feel in control and be aware of what was happening to him. But, extreme pain is one of the accompaniments of terminal cancer. Nursing and medical management are directed toward the alleviation of this pain. One of the goals of treatment is to maintain the patient as comfortably as possible. Excruciating unalleviated pain coupled with the knowledge of impending death can and does distort and reduce the patient's awareness. Medication affords some measure of relief as do other nursing measures. As well, a patient who feels trust in and comfort from those giving him care will be more relaxed. Anxiety only serves to accelerate and enhance pain. Demerol, while an effective analgesic, is not as effective as morphine under certain conditions. Some authorities believe that when pain is severe, the analgesic value of morphine has no rival.

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Here, the physician's order clearly documented the option of using either Demerol or morphine. There was no prohibition of the use of morphine. The option existed out of respect for the patient's preference. However, it existed also to be exercised at the discretion of the nurses based on their professional assessment of the patient's needs.

Hospitals and their staffs are required to give the best possible medical and nursing care within the limitations of the patient's refusal. But a patient cannot demand mistreatment. Nor can he bind staff into a promising mistreatment.

Furthermore, a patient's refusal should be as 'informed' as his consent. This does not mean that the patient's reasons must be rational; they may seem foolish to 'outsiders'. Informed refusal means that the patient was given sufficient information to make an informed decision.

In this case, one might question the 'informed' aspect of the patient's preference. Peter's fear of morphine may have been rooted in misconceptions as to the drug's use and effect. The question is whose judgment should prevail?

A patient having stated a preference in the absence of pain clearly has the right to change his mind. A woman espousing natural childbirth can opt for an epidural once labor starts. Similarly, if conditions are such that in medical judgment natural childbirth is untenable, the patient's preference would no longer prevail. So, here, if the nurse who was looking after Peter judged that the administration of morphine was indicated, she had the right to give it.

Was she bound to tell Peter that the medication she was giving WAS the morphine he dreaded? At this point, personal professional and ethical values come into play. Nurses, like physicians, are not bound to disclose information that might frighten or distress the patient. Often, in the course of their practice, they may feel and in fact are called upon to skirt the truth. When, for example, a patient's diagnosis is terminal and there are valid reasons for not informing him, nurses continue to give care in a positive atmosphere and with a hopeful attitude. Their words and deeds deny the diagnostic reality.

When she decided not to tell Peter that the medication was morphine, the nurse may have wished to spare him that additional distress and anxiety which, in her professional judgment, would have countered the therapeutic effect of the morphine. She may have thought that, given the severity of the patient's pain, the administration of morphine would reduce that pain and eliminate its distorting effect on the patient's awareness.

After all, Peter's goal was to maintain awareness!

Perhaps underlying the whole question lies the nurse's well meaning desire to care for the patient. There may be a basic presumption that no one wants to die in pain — certainly not by choice. In a society that toasts youth and life, the youthful dying patient elicits emotional responses within those giving care. While emotions should not dictate the exercise of professional judgment, this element cannot be ignored.

Where the patient's choice clashes with professional judgment, given an emotional overlay on both sides, properly executed professional judgment may prevail. The nurse's administration of morphine in effect would have furthered the patient's hope of meeting death with as much awareness as could be expected in the circumstances.



"You and the law" is a regular column that appears each month in *The Canadian Nurse* and *L'infirmière canadienne*. Author Corinne L. Sklar is a nurse and third-year law student at the University of Toronto.

Nurse practitioners — the national picture

1. In December, 1971, a special committee consisting of three doctors and three nurses was set up to study the role of the nurse practitioner in the overall scheme of Canadian health services. The Minister of Health at the time, the Hon. John Munro, named a member of the faculty of the University of Sherbrooke, Thomas J. Boudreau, to head the committee.

2. When the Boudreau Committee, as it became known, presented its report to the Minister five months later, its central recommendation was that "the development of the nurse practitioner category be regarded as the highest priority in meeting primary health care needs in Canada" and that "pilot or demonstration projects utilizing nurse practitioners be developed in many parts of the country and appropriately evaluated."

3. During their investigation the committee found that the term nurse practitioner was currently the subject of a wide range of interpretations. At one extreme the term was taken to mean recognition of an expanded and well-defined role for nurses as nurses, and, at the other extreme, as the utilization of nurses to assist physicians in carrying out their functions. Members expressed the opinion that, given adequate preparation and experience, nurse practitioners could function in either role and said they hoped that eventually the two extremes would be reconciled.

4. Recognizing the shared functions between medicine and nursing, the committee members conceded that often the skills of the nurse "are substitutable for, as well as being complementary" to those of the physician. They then suggested a list of eleven functions that the nurse practitioner might undertake. They noted that these functions implied "a much broader range of activity than has been the case in the traditional role of the nurse in primary care" and added that this meant that the nurse practitioner would have to "exercise more independent judgment than has been permitted heretofore."

5. The committee opted for flexibility in the development of career patterns for nurse practitioners and recommended that the title be utilized "according to the needs of the systems for such a person and the capacity of the candidate to fulfill the role," rather than being rigidly tied to any specific level of education.

6. In the long run, the committee concluded, preparation of nurse practitioners should be incorporated into basic nursing education programs — at both diploma and degree levels. Until

these courses could be modified to meet this broadened concept of nursing, however, nurse practitioners should receive special preparation in courses to be offered conjointly by university faculties of medicine and nursing.

7. Looking ahead, the committee predicted that acceptance of nurse practitioners on a widespread basis would be a gradual process and would depend upon attitude changes leading to acceptance by other health professionals.

Another problem recognized by the committee concerned the difficulties of developing a "multidisciplinary team approach" if the members of that team continued to be remunerated in different ways — i.e. fee-for-service as opposed to salary. The Committee commented that "recommendations regarding payment of other members of the health team" were not within their terms of reference and expressed the opinion that "the preferred mode of remuneration for nurse practitioners in both the public and private sector was sessional, weekly or annual salary, at levels equivalent to those received by nurses working in related fields of education or administration where comparable levels of responsibility are exercised."

Since the time of the Boudreau Report, a number of programs for nurses in an expanded role have been developed in universities across the country. The goals of these programs tend to fall into two broad categories. Some of the programs were specifically funded to provide nurses with the special skills needed to function in northern outpost settings. Dalhousie University in Halifax had already begun a two-year course leading to credentials in midwifery and outpost nursing in 1967. Six other programs to prepare nurses for work in the north were started in 1972 in conjunction with Medical Services Branch, Health and Welfare Canada. These were located at the Universities of Alberta, Manitoba, Western Ontario, Toronto, McGill and Sherbrooke.

The goal of the second group of programs was to provide nurses with skills in primary care to be used in family practice settings, clinics, community or public health settings etc. in both rural and urban areas. McMaster University and the University of Montreal started their programs in 1971. Other programs were begun later at the University of British Columbia and at Memorial University of Newfoundland.

At the present time, only a few of these programs are still in operation. Some universities are trying to incorporate "expanded skills" into their basic baccalaureate nursing programs; others have found that such programs are just too expensive and government funding is not available.

The nurse practitioner— what happened?

an interview

Sandra LeFort

Dorothy Kergin, associate dean of health sciences at McMaster University in Hamilton, Ontario is considered by many to be one of this country's leading exponents of an expanded role for nurses working in a primary care setting — whether that setting is in the office of a family doctor, a community clinic or a nursing station in an isolated or rural area of Canada. As director of McMaster's school of nursing, Dr. Kergin was instrumental in setting up one of the first family nurse practitioner programs in Canada, an eight-month program that has since been re-named the Educational Program for Nurses in Primary Care. It got its start in 1970 and since then approximately 20-25 students have graduated each year.

Dr. Kergin has described the nurse practitioner as "a nurse in an expanded role, oriented to the provision of primary health care as a member of a team of health professionals relating with families on a long-term basis and who, through a combination of special education and experience beyond a baccalaureate degree or a diploma, is qualified to fulfill the expectations of this role."

She is a strong advocate of the cooperative approach to the provision of health care and believes that "if nurses are to influence planning and expenditures, we must direct our attention towards the interdependence of nursing and other health professions rather than persisting in our attempts to define areas of independent practice." She warns that "nursing in isolation can neither control nor direct change. By working with others, we can — we must — moderate it. Should we fail, we cannot anticipate an expanded role for the nurse, but, rather, a shrinking one."

In the interview that follows, Dr. Kergin and Mona Callin, director, Educational Program for Nurses in Primary Care describe the changes that have taken place in the McMaster program since it was set up six/seven years ago, the reaction of doctors, patients and nurses themselves to the nurse practitioner role and some of the practical problems standing in the way of recognition of the contribution that nurse practitioners can make to more comprehensive health care.



Dorothy Kergin



Mona Callin

CNJ: *Tell me about the nurse practitioner program at McMaster. What is the focus of the program?*

M. Callin: There are three aspects of the program which I think have been important right from the beginning. The first area that we emphasize is the "role change" that must occur in both the nurse and the physician. The nurse will be functioning in a much different capacity when she returns to the work setting as a nurse practitioner; she is going to be more of a colleague with the physician. This kind of role change affects the nurse and everyone else in the practice. That is why we believe it is of vital importance to have the physician, with whom the nurse will be working on completion of the program, actively involved in the learning process, particularly in the nurse's clinical practice.

Our program is directed to both the physician and the nurse. Together they work on increasing her skills and on the role realignment so that by the end of the program, they have developed a new way of working together as a team.

CNJ: *Is this kind of physician involvement unique to your program?*

M. Callin: Yes, I don't think any other program in the country requires the same level of physician participation as we do. We give a lot of attention to role change.

The second aspect that the program emphasizes includes those things that we feel the nurse practitioner does particularly well, things that are related to health rather than to disease, diagnosis and treatment which are really in the physician's realm. So the medical concern is disease and its treatment, alleviation and prevention but the nurse's area is promotion of health. That can be practiced in well-person checkups, whether baby or adult. It also has to do with the functioning of normal processes: growth and development — child and prenatal care; the adolescent stages — counseling young people who are coping with growth and personality changes and feelings of alienation; the normal aging process — care of the well elderly.

And the third area of importance is the care of family health problems which the nurse is likely to see and is able to develop skills in looking after. Examples of this are episodic problems that are relatively common and uncomplicated such as sore throats, colds, flus, earaches — that kind of thing.

Involved in this area too is the care of people with chronic health problems such as arthritis, diabetes or hypertension. The monitoring of the problem, helping the patients to maintain

compliance with the treatment plans, and helping them to cope with the frustrations of living with these problems are all very important functions of the nurse practitioner. Those along with helping families deal with emotional problems, crisis, anxiety and depression are what we see as areas in which the nurse practitioner can be a skilful and effective provider of care.

So those are the three areas we have focused on since the start of the program: role change, promotion of health and care of common health problems.

CNJ: *When the nurse practitioner program at McMaster got underway in 1970, it was the first of its kind in Canada wasn't it? Can you tell me a little bit about how it got started? Why, for example, did the Ontario government decide to fund the project?*

D. Kergin: Like many governments the Ontario Ministry of Health was convinced that demonstration projects and research in the primary care field were worth doing. A big factor too, was the number of what they termed "medically underserved" areas in the province. The Ministry was interested in having nurses as providers of primary care in some of those underserved areas. Our provincial funding for 1970 and subsequent federal funding centered on providing care in these "underserved" areas rather than isolated areas.

CNJ: *I see. So nurse practitioners were supposed to fill that gap?*

D. Kergin: Yes. Except that in the interim, partly through the influx of foreign physicians but also because of the productivity of medical schools, there have been doctors entering these underserved areas. A good example of this occurred during one of the trials conducted in Beaverton, an area in southern Ontario. A VON nurse who took the McMaster program went back to the VON to be attached to a physician practice. This joint nurse-physician practice demonstrated considerable cost saving and also demonstrated that the nurse-physician team was better able to provide care for that community than the physician alone had been able to before. People were being kept out of hospital. But Beaverton was still identified as an underserved area. Just at the end of that phase of the study, the province was successful in recruiting a physician for that community and once the second physician was there it was not economically worthwhile for the nurse-physician team to continue with their project.

CNJ: *Is there still this influx of physicians?*

D. Kergin: Well since that time the federal government has put very severe restrictions on the immigration of physicians. It is pretty difficult to get in now. But of course, the medical school enrollment has risen considerably.

CNJ: *In effect, then, physicians are experiencing some of the same difficulties that nurses are having now as far as finding jobs in certain areas of the country?*

M. Callin: Yes. You see in 1970 there was a shortage of physicians and consequently a need for nurse practitioners as additional personnel to provide adequate family care for the community. So the nurse practitioner wasn't a threat, she was an asset. Now, there is a surplus of physicians and people are perceiving the situation in a different way. Some physicians acknowledge that nurse practitioners make important contributions to primary care but they are unable to employ them because of the lack of reimbursement for their services under provincial health insurance plans.

D. Kergin: You have got to keep in mind too that just after 1971, the salaries of nurses rose very sharply at the same time as costs and prices were going up. When you balance that with the increasing overall cost of our health care services which are directed for the most part toward secondary and tertiary care levels, then the nurse practitioner in primary care is viewed by most governments to be an add-on expense.

CNJ: *But my impression of a nurse practitioner was that he or she would be someone who would be bringing different skills to an office or clinic setting than a doctor brings — not take the place of a doctor — and that efficiency and patient care would be enhanced. In view of the fact that most physicians have an office nurse already it seems very sensible for that nurse to be able to expand her skills and to use them in contact with patients.*



D. Kergin: Yes, that would be our assumption too and there are hints of that in some of our studies. But the problem is that physicians are on fee-for-service. A doctor cannot bill OHIP (Ontario Health Insurance Plan) for services provided by a nurse unless the physician is actually involved in the care. It's our funding system under fee-for-service that causes most of the problems.

Now there are other alternatives. For example, some group practices and community clinics are on a global budget arrangement rather than on fee-for-service. Under this kind of arrangement the Ministry of Health says to a clinic or group practice, "Okay, based on your volume of practice in the past, we would estimate that you would earn this much during the upcoming year ... so we will guarantee you that much..." A global budget then guarantees them a certain income regardless of the number of patient visits. The clinic can decide how they are going to spend this money — for example, hire a nurse practitioner. In the long run, there probably will be a demonstration of cost saving from this method of payment but it's too early to tell yet.

So far, I think there are about 30 clinics or group practices under global budget in Ontario.

CNJ: *The province has designated these practices for global budgets?*

D. Kergin: Yes. These would be practices that have a sufficient volume of practice and the physicians are interested in going on global budget, which is a form of remuneration other than fee-for-service. But it is a complex problem. And now of course the politicians are telling the Ministry of Health to hold down its costs and so we see them putting restraints on hospitals, restraints on public health agencies and refusing to add anything or anyone that may raise costs. So the economic problems for the nurse practitioner are really greater than the legal ones.

CNJ: *From what you are saying the main problem in the utilization of the nurse practitioner is a financial one.*

D. Kergin: Basically, it is, yes. We're beginning to hear that there's more interest in salary arrangements among physicians but the province is more interested in salary or global budget arrangements for group practices where there will be an expectation of greater efficiency. They are not interested in putting solo practices on salary where it is much clearer that the addition of a nurse practitioner would be an "add on" expense. While it may be doing a better job for a group of patients, it is not economical.

CNJ: *Would there be any way of having nurse practitioners go on fee-for-service so that they could be paid directly for the patients they see?*

D. Kergin: I don't see this happening. I don't believe any of our provincial governments is interested in adding new health professionals to the fee-for-service method of payment.

M. Callin: Looking at it from another point of view, I think expanding the fee-for-service system to include other members of the health care team has the potential for placing a range of price tags on the care provided. It could suggest that because care provided by one member of the team is more costly, or less costly than that provided by another, it must be superior or inferior. This approach does not take into consideration, how well the patient's needs are met but only which category of health professional is giving the care.

D. Kergin: A more appropriate direction, I think, is to look at what case load a practice has and the cost incurred and then assume that there is going to be an annual increase due to inflation. Then, guarantee the practice that much. At that point, the practice team can decide who is going to deliver that service.

CNJ: *Are all the nurses who enter the program at McMaster from a family physician setting?*

M. Callin: No, this isn't true any longer although that was the case in earlier years. In the early '70s, almost all the students were in family physician settings. Now, we have people coming from a variety of primary care settings — public health, industrial health, emergency room or student health services in a college — all of which are ideal situations for the nurse practitioner. That was why we changed the name of the program from the Family Practice Nurse Program to the Educational Program for Nurses in Primary Care.

CNJ: *Considering the change in the name of the program, is the nurse who completes your program still able to call herself a nurse practitioner?*

D. Kergin: Well anyone can use the name "nurse practitioner" in Canada since it is not a protected title — that is part of the reason why there is confusion about the nurse in an expanded role. From the very beginning of our program however, we said that the student completes a program in primary care as a nurse practitioner. We do not confer the title "nurse practitioner."

CNJ: *I see. Is this true for the nurse practitioner in the U.S. as well?*

D. Kergin: In some states legislation has been passed to protect the title of nurse practitioner. This means an individual must have completed a recognized program and can carry out certain responsibilities which other nurses cannot. None of the provinces in Canada have passed this kind of legislation.

CNJ: *What do you think of the idea of the independent nurse practitioner?*

D. Kergin: Well, I very strongly support the multi-disciplinary approach to health care which includes nurses, physicians, social workers, physiotherapists etc. Health care requires the skills of all these people so making them all independent isn't in my view the route we should be going.

CNJ: *Do nurse practitioners ever go into the hospital settings to visit patients?*

M. Callin: They may, but it is not common practice. I think the important issue is the nurse practitioner's reason for going to the hospital. If she is going in a nursing capacity to see a postpartum mother as a follow-up of her prenatal care, for example, or to maintain contact with a patient with a chronic health problem, well, that's fine — but if she is going to the hospital to make rounds on behalf of her physician as a physician assistant or a physician substitute, I can see many complications arising. In this situation, there is potential for conflict between the nurse practitioner and the head nurse regarding responsibility of the nurses on the unit for nursing care.

D. Kergin: Or else it's a waste of time.

CNJ: *Do you see a swing towards primary care skills such as basic diagnostic skills, history taking etc. being taught in basic nursing programs?*

D. Kergin: I think many of us would say that some of the changes occurring in the basic and post-basic programs are meeting the expectations of the Boudreau Report. Now, a great debate has ensued as to whether or not nurses who graduate from these programs with a B.Sc.N. are nurse practitioners. You can get into all kinds of debate, some of it pretty heated, about who is a nurse practitioner. In my view, what we are looking at are nurses who are well prepared to provide primary care services be it through basic baccalaureate programs or through a post-basic primary care program such as the one Mona directs.

CNJ: *Can you tell me how nurses who have taken your program feel about the work they do as nurse practitioners?*

M. Callin: I would say that the majority of them find primary care a very satisfying work experience. We have to look at the people who come into the program. They are probably unique, a little different from the general nursing population. One study* suggests that nurse practitioners tend to rate low on nurturance, deference, and order and high on independence, change, flexibility and self-acceptance. I think these qualities can be expected of a nurse working in an expanded role and in a colleague relationship with a physician. When the abilities of the worker and the demands of the job fit together well, job satisfaction is usually achieved. Most practicing nurse practitioners seem to find their work very challenging and very rewarding.

CNJ: *What about physicians? Are they happy about the nurse practitioner?*

M. Callin: The physicians who have participated in the program I would say, are quite satisfied. I don't think that the nurse can be happy in her new role unless everybody from the receptionist on is keen on the idea.

CNJ: *And what about the patients? I know that the Burlington studies have shown that patients' reactions are very favorable.*

M. Callin: Yes, on the whole, I would say that nurse practitioner acceptance by patients is very good. Once the patient understands the team approach to patient care, sees the competence of the nurse practitioner and observes the physician's confidence in her ability, there are usually very few problems.



CNJ: *What about the nursing population, have they accepted the nurse practitioner?*

D. Kergin: I'd say yes, they have. One evidence of this is the fact that nurse practitioners have organized as an interest group in Ontario and in Manitoba. So I feel encouraged. I think nursing in general sees this movement as a way that nurses can use the skills and abilities that they already have and enhance them, to strengthen the caring aspect of health services instead of the curing aspect.

Perhaps one group that has seen it from the beginning with a little bit of anxiety is the public health nurses. They see the nurse practitioner who is associated with a family physician as doing things that the public health nurse already knows how to do but hasn't been allowed to do because of the gap between the family practice and the public health agency.

The utilization of nurse practitioners in public health settings is where research is being directed right now.

CNJ: *What does the future hold for the nurse practitioner in Canada?*

D. Kergin: It will all depend on what the government decides regarding fee-for-service, particularly with respect to physicians in family care settings and whether governments are willing to divert a greater portion of the health care dollar toward primary care. If they are going to continue fee-for-service and restrain both community and hospital sectors, then the outlook for the nurse practitioner is not very good. But there are certainly other places where the nurse practitioner can function equally well, public health nurse-attachments, occupational health and geriatrics. There is a particularly great need in geriatrics with the increasing aging population. It all comes down to whether or not agencies have the funds to employ one.

I don't think that there is any question but that the nurse practitioner is a good product but it's a matter of whether the market can support it. ♡

* White, Martha Sturm. Psychological characteristics of the nurse practitioner. *Nurs. Outlook*, 23:3:160-166, Mar. 1975.

To find out more about the situation of the nurse practitioner in Canada, CNJ contacted representatives from across the country and asked them to comment on what is happening in their province. This is what they had to report:

● British Columbia

"Nurse practitioners" work in a variety of settings and in diverse roles in British Columbia. In the four demonstration Community Health and Human Resources centers in the province, nurses are involved in primary health care, seeing patients in the centers and making home visits. A recent report of the Audit Committee for these centers found that patient acceptance of the nurses was high, that the nurses were generally pleased with their role and the physicians favored the use of nurse practitioners. In addition, there are four "free clinics" in the province which also make considerable use of nurse practitioners. Their responsibilities in these clinics are principally patient teaching and primary health care. Nurses who are working with residents of provincial senior citizens' housing projects are very much involved in assessment and maintenance of people who have chronic health problems.

The provincial government has placed two nurse practitioners in remote areas of the province; one is on an island and the other is situated in the northern interior. Both of these nurses are in communication with physicians, either by radio or telephone, and provide primary health care and emergency services for the residents of their respective areas. Finally, there are nurses who are working in expanded roles in physicians' offices in various parts of the province.

As you can imagine, there have been problems with the introduction of nurse practitioners into the health care system. Fortunately public acceptance of these nurses has not been one of them. From time to time there is an indignant gasp from a physician who has decided that nurses are practising second-rate medicine, but these are sporadic and often come as a result of the physician's acquaintance with the literature rather than firsthand experience with nurse practitioners. Money is a problem for nurses who are working in physicians' offices insofar as they must generate their salaries out of fees-for-service to the physician.

There are also some administrative problems within the provincial health departments for those nurses who must become a part of the mainstream of the health care system. For example, it is difficult to decide how they fit into the nursing hierarchy. If they are seconded to a community health and human resources center then their supervision and evaluation by persons other than nurses becomes problematic. If they are part of a nursing service then their position descriptions tend to become a conglomeration of patient care, teaching and administrative responsibilities. Those nurses who are in remote areas must not only report to their public health nursing supervisors, but they also have responsibilities to the physicians with whom they work. It is doubtful whether these situations present problems, inasmuch as they are the concomitance of orderly change in the introduction of new roles and functions in the health care system.

Regarding the education of nurse practitioners in this province, it was initially recognized that a post-basic expanded role of the nurse program was a stop-gap measure and that preparation for expanded roles in nursing should be at least at the baccalaureate level. Beginning in April, 1977, the University of British Columbia has graduated nurses who are capable of undertaking an expanded role.

● Alberta

The vast majority of nurses who enrol in the Nurse Practitioner Program at the University of Alberta are employees of Health and Welfare Canada who return to northern nursing stations upon the completion of the course. The Northwest Territories have the greatest number of nursing stations and thus the majority of graduates work in that region. At present, the 12th Nurse Practitioner Program is in session and to date 86 students have graduated from the course.

In the province of Alberta itself, there are three Health and Welfare nursing stations employing a total of five nurse practitioners, all graduates of the U. of A. program. These nurses receive an educational bonus if they do not already receive additional monies for advanced degrees (e.g. B.Sc.N.). The provincial government also has a few rather isolated health centers and has employed nurse practitioners in the past. Recently, the government has expressed interest in staffing some positions in these centers with graduates of the program. In this case, however, the nurse would not receive additional remuneration for her advanced preparation.

Several other nurse practitioners are employed by local health units but at present, they are not making full use of their "expanded" nurse practitioner skills. Several agencies in Edmonton are currently employing nurse practitioners or hope to do so in the near future and have expressed an interest in sending candidates to the U. of A. program. Generally speaking, remuneration is still a stumbling block. Only one agency in Edmonton has defined a new category of "nurse practitioner" in their pay scheme.

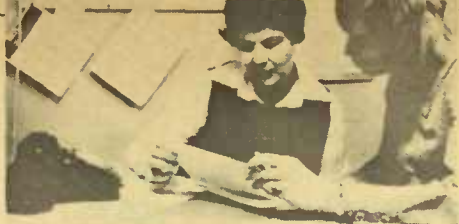
At present, the employment opportunities for nurse practitioners to use their "expanded skills" are few in urban and rural settings in Alberta. However, interest in the concept seems to be growing. A 1977 report on *Employment Opportunities for Nurse Practitioners in Alberta* concluded that there is a definite market for nurse practitioners if these personnel have additional preparation such as a B.Sc.N. degree.

The Alberta Association of Registered Nurses has recently agreed to set up an employment roster for nurse practitioners and any available positions will be communicated to them.

● Saskatchewan

From 1974 to 1976, four nurses with special preparation were functioning as nurse practitioners in selected rural southern Saskatchewan communities where there were no resident physicians. It was for these medically underserved areas that the Saskatchewan Nurse Practitioner Demonstration Project was designed. As a pilot project, it was funded by the provincial government to run for two years and then was evaluated. In June of 1977 the joint committee supervising the nurse practitioner program recommended that the project end.

It is distressing that a majority of people view the Saskatchewan Nurse Practitioner Demonstration Project in a negative light — how unfortunate it is that the project did not meet expectations, was unsuccessful and therefore discontinued.



In actuality we must remember that it was a "demonstration" project and always did have a terminal date in the schedule. As a demonstration project we feel it did, in fact, very successfully fulfill the function it set out to—that of testing a unique nurse practitioner concept when compared to projects in other provinces. You will recall that the nurse practitioners in this program were not placed in a physician's office or clinic but rather in an *independent* setting in the community. They were expected to assume a greater degree of independence and were given a broader range of functions including the prescribing of drugs.

A great deal of useful information was obtained from the study. For example, it was quite clear that the development of the role envisaged for the nurse does not just happen. It must be nurtured by association with a role model who has the same professional duties. As there were no other nurse practitioners in the province at the time of the study and as the four project nurses were geographically isolated from one another, they logically chose to pattern themselves in practice after the most convenient model, the physician. The provision of care remained principally episodic and cure-oriented. Another contributing factor was that in a few instances where the nurse practitioner should have taken on services being provided by other branches of the Department of Health, administrative arrangements necessary to permit this were unable to be made.

It is also quite evident from the collected data that many of the health professionals with whom the nurse practitioner came in contact were not wholly supportive of the project and in some instances were less convinced of the need for service than was the public. This resulted in a feeling of isolation for the nurse.

Clients who sought care found the program acceptable and wanted either a physician or nurse practitioner to be resident in their community. In the towns where the nurse practitioners were located, the proportion of the population receiving one or more services from her over an eighteen-month period showed a low of 62 percent and a high of 86 percent. The clients appeared to be selective about those complaints for which they consulted the nurse practitioner and those where they consulted a physician. The communities' perception of their needs was not always what the planners had in mind as the function of the new service.

Measurement of the constraints on health care costs were very limited. Neither hospital nor physician utilization rates seem to have been consistently altered in the areas served by nurse practitioners.

The instrument developed to evaluate the quality of care provided proved to be a sensitive measure of quality and merits replication on a larger number of nurse practitioners than the four included in the study. It gave us definite data on the progression of the nurses in all aspects of care envisaged from physical assessment to health teaching and health hazard appraisal.

It would seem the results show that it is viable for nurses to function independently in a rural area if they have adequate back-up in terms of supervision and support. They also show that at this time there is no crying need for such nurses in the south of the province (the isolated northern areas have always had this need — but that is an entirely different situation).

Three out of the four nurse practitioners are presently involved in more traditional nursing roles and further study is being done by professional nurses and government as to the future of the nurse in the expanded role in Saskatchewan in light

of the Demonstration Project results.

Readers who wish more background on this project are referred to: *Nursing Clinics of North American*, Vol. 10, No. 4, December, 1975, "The Independent Nurse Practitioner, Alive and Well and Living in Rural Saskatchewan" by Barbara Cardenas.

● Manitoba

Initial interest in nurse practitioners, or nurses practising in an expanded role, was indicated by the Manitoba Association of Registered Nurses in 1971-72 when an ad hoc committee was set up to study this subject. As a result of the committee's work, a position paper outlining the preparation and role of the nurse practitioner was approved and revised by MARN in 1974 and 1976 respectively.

In 1975, a few nurses in Manitoba who were working in an expanded role and providing community primary care services formed an Interest Group. Since that time the group's primary goals have been to provide educational seminars and promote nurse practitioner services in Manitoba.

The Nurse Practitioner Interest Group includes approximately fifteen nurses with specialized clinical preparation and ten nurses who are either working or interested in the nurse practitioner role. Nurses with advanced preparation received this from a variety of settings including the University of Saskatchewan, McMaster University, University of Washington, University of Manitoba School of Nursing, and the Northern Medical Services program offered by the University of Manitoba Faculty of Medicine. Seven nurses in the province completed a nine-month program given by the School of Nursing, University of Manitoba in 1974-75 and after that year the program was terminated. At present in Manitoba, only the Northern Medical Services program prepares nurses for an expanded role, and qualifies approximately eight nurses per year to work in remote communities.

Most nurse practitioners in Manitoba work in community clinics or provincial health units. Most of them would describe their role as being the provision of primary care — i.e. being a person's first contact in any given episode of illness leading to a decision of how to deal with this problem, and being responsible for the continuum of care, including health maintenance, periodic evaluation of chronic illness and referral when necessary. Clinical management of patients has been facilitated by the nurse's expanded skills in history taking and physical assessment, and by a collaborative relationship with physicians and other health providers.

Nurse practitioners are largely employed on salary by the government. There are a few nurses working in hospital outpatient clinics in specialized areas, some under special project grants. So far, there are no nurse practitioners known to be working in "fee-for-service" or private settings; this is an area in which patients could certainly benefit from nurse practitioner services.

In Manitoba, the College of Physicians and Surgeons has been generally supportive of the MARN position paper, of 1974 and '76, on nurse practitioners. Physicians working with nurses in



community clinics have, for the most part, been helpful as nurses have undertaken this new role. But some physicians see the nurse practitioner as an economic threat.

Patients have been accepting of the nurse's care and often express their appreciation of the time allowed for explanation and counseling. Elderly patients are pleased to have someone visit and assess their condition in their homes.

The future for nurse practitioners will depend upon the positive support of the medical and nursing professions, and the public. The Nurse Practitioner Group in Manitoba recently presented a brief to the government emphasizing the need for educational preparation, formal recognition of nurse practitioner programs, and the development of job opportunities. Research studies to date evaluating the quality of care and cost of nurse practitioner services should be continued, and will be useful in persuading governments to support nurse practitioner programs.

Ontario

The interview with Dorothy Kergin and Mona Callin on page 15 covers many aspects of the Ontario situation for the nurse practitioner. Ontario, like Manitoba, has a nurse practitioners' association. To add another dimension to the previous discussion, CNJ asked the NPAO to comment on their organization:

Educational programs for nurse practitioners began in Ontario between 1970 and 1972. In 1973 interested graduates of these programs expressed the need and desire to form an organization which would specifically represent nurse practitioners. Consequently, the Nurse Practitioner Association of Ontario (NPAO) was established.

Membership in the NPAO has increased to 124 active and special members at the present time. Active members are graduates of recognized nurse practitioner programs in Ontario. Special members are graduates of recognized nurse practitioner programs outside Ontario or are nurses who have special education acceptable to the executive committee of the NPAO. Current members of the association received their nurse practitioner education in programs conducted at McMaster University, the University of Toronto, the University of Alberta, Dalhousie University, and the University of Virginia. Graduates of the Clinical Training of Nurses Program at the University of Manitoba and the University of Western Ontario are also eligible for membership.

A look at the places of employment or the type of nursing undertaken by active members in 1977 gives an idea of the scope of the nurse practitioners' involvement in the health care system. (See Figure 1)

Unfortunately not all of these nurses are functioning fully as nurse practitioners. At the present time some barriers still exist which prevent many nurse practitioners from completely developing their roles.

A major objective of the NPAO is to ensure that the education, regulation and discipline of nurse practitioners remain within the realm of nursing. With this in mind, the NPAO decided to become an affiliate group of the Registered Nurses' Association of Ontario (RNAO). This affiliation has provided the

NPAO with much support and with a forum for the exchange of information and ideas. Representatives of the NPAO have been invited by the RNAO and the College of Nurses of Ontario to sit on the following committees:

...A Working Party of the RNAO regarding Nurse Midwifery
 ...A Working Party of the College of Nurses of Ontario studying health assessments by registered nurses
 ...An ad hoc committee to develop a statement on the role and function of the nurse practitioner (RNAO).

All members of the NPAO are encouraged to study and respond to issues relevant to nursing generally and to the nurse practitioner specifically. At present, members are reviewing the proposals of the College of Nurses of Ontario regarding certificates of competence and are attempting to define standards of practice for the nurse practitioner.

Another objective of the NPAO is to educate the public and other members of the health team about the present and potential role of the nurse practitioner. Members are encouraged to speak to interested individuals and groups about the role, to write articles and to conduct research to increase the visibility of the nurse practitioner in the health care system.

The provision of opportunities for professional development is a further objective of the NPAO. Annual meetings and workshops allow nurse practitioners to increase and update their knowledge and skills through seminars, clinical sessions and discussion groups. Two or more newsletters are circulated to members each year. They contain association news as well as information regarding current trends in nursing and research and publications, related to the nurse practitioner. The NPAO keeps its members informed of continuing education programs and financial assistance available for these. It also forwards news of employment opportunities to the RNAO Referral Service.

Nurse practitioners in Ontario continue to grapple with issues such as definition of roles, acceptance by the public and other health professionals, establishment of legal terms of reference, salary scales and educational requirements. Members of the NPAO remain convinced, however, that the nurse practitioner has a significant and necessary role to fulfill in the delivery of quality health care. The members would welcome correspondence both from prospective members and from people interested in fostering the concept of the nurse practitioner.

Please write to: Susan Grimshaw Levesque,
 2672 Bayview Avenue, Willowdale, Ontario, M2L 1B9.

Figure 1

Doctors' Offices	29	Children's Aid Societies	2
Community Health Centers	18	Victorian Order of Nurses	2
Family Practice Units	11	Home Care Programs	1
Hospital Specialty Clinics	8	Family Planning Service	1
Public Health Units	5	Infirmary in	
Teaching Positions	4	Correctional Institution	1
Occupational Health Units	4	Ministry of Health	1
Northern Nursing Stations	3	Psychiatric Hospital	1
General Duty Nursing	2	Not currently practising	16
TOTAL			109



Commentary: College of Family Physicians

Your invitation to extend comments concerning the nurse practitioner on behalf of the College of Family Physicians is appreciated.

I personally became interested in the concept of the nurse practitioner in the late 1960's and early 1970's. At that time I perceived myself to be grossly overworked and believed that an appropriately trained Registered Nurse could share an appropriate portion of my workload such that I would have more time for difficult cases. In addition, I could see a host of useful things that the nurse could do to extend the quality of my practice in her own right. One could think of such things as dietary counseling, psychological work-ups for family counseling as well as more traditional concepts such as well-baby care and prenatal care.

I felt strongly and still do that the nurse practitioner and doctor should work together as a team and avoid further segmental fragmentation of primary care where at all possible.

The College of Family Physicians of Canada hosted a workshop about 1971 to further explore these and other concepts. Appropriate representation was present from the nursing profession. Some very good model practices were established demonstrating that many of these concepts had validity. Some few models are still in practice today. However, some things began to go wrong.

On the part of the private physician — many enjoyed the new expanded role of the nurse and the new relationship. However after some years of experience it became evident that, by and large, physicians who had nurse practitioners were not doing as well financially. Our provincial Ministries of Health did not provide the necessary funding mechanism so that the nurse could earn her keep so to speak and at the same time the physician not suffer a loss.

In Ontario, for example, an OHIP card could not be forwarded for collection unless the physician also personally reviewed each and every case with the nurse and patient. A number of models which were funded in a different way and associated with the Department of Family Medicine at the university were able to carry on quite nicely.

In more recent years both the medical and nursing professions have witnessed a catching up and surpassing of the manpower needs in their respective professions. In a large way this has diminished the need for the development of the nurse practitioner.

I still think there is a very important role for such a person in situations such as the Sioux Lookout Zone of Northern Ontario. I personally was privileged to travel to this area on two occasions. One to specifically assess the work of the nurse practitioner. I was impressed and delighted with the expertise with which these nurses executed their responsibilities.

The present sadness is that all we hear from the Ministries of Health at the present time is that no new programs are to be developed, no new funds are available for extensions of service in any way. This situation is made sadder by the fact that for the first time in our history, there are sufficient nurses available who are exceptionally bright, well-trained and well-motivated, but who cannot find work. Which takes me back to my original comment. If they were keenly interested in improving the health of the people at the primary level, to promote healthier lifestyles, a very logical place to begin would be to provide incentives for physicians to employ family practice nurses within their offices.

In conclusion, the family practice nurse was never intended to provide cheaper medical care for the citizens of our country, but rather comprehensive care that the Canadian public would soon learn to appreciate.

Yours sincerely, Hollister F. King, M.D., C.C.F.P. - President.

Quebec

It is difficult to discuss the role of the nurse practitioner or the nurse in an expanded role in Quebec without first discussing the immense changes which have occurred in the delivery of health care in the province since 1973, particularly in the area of community health.

In January of that year, the Act respecting Health and Social Services and its Regulations was implemented in Quebec. The province was divided into ten health regions, each with a regional health office and advisory council. Within each region, health care services were further broken down into four categories:

- hospital centers (H.C.)
- reception centers (R.C.)
- social service centers (S.S.C.)
- local community service centers (L.C.S.C.).

The biggest change, as I have previously mentioned, is in the area of public or community health. In Quebec, the Community Health Department is located within the hospital setting itself. The Department is responsible for what traditionally are public health concerns, and also for service areas of the hospital such as emergency, out-patient clinics and family health units.

By talking with some nurses in these service areas I gather that they are or are trying to be the first contact with the client and/or his family. Nurses who are presently in the role of first contact and who exercise the functions that this role implies have a strong professional base and work in a milieu where change is allowed. The work that these nurses do has a strong clinical component and some people would call them "nurse practitioners."

Nurses who work in the public health sector of the Community Health Department are involved in many activities including the planning and executing of specific programs such as perinatal, school health and occupational health programs. Nursing education has accommodated this shift to community health by incorporating it into baccalaureate programs and by providing a certificate program in community health.

In conclusion, if we look for "trained" nurse practitioners in this province, we will find only a few. But in reality, there are nurses functioning in an expanded role. Included in this group are the nurses working in rural areas of the province such as the regions of Nouveau Québec, Côte-Nord, Nord Ouest. In these regions, nurses are in many instances performing a "medical replacement function."

IN THE UNITED STATES*

Across the border, prospects for the nurse practitioner appear somewhat less uncertain. Numbers are stronger, more training programs exist and economic and legislative developments would seem to favor public recognition of an expanded role for nursing within the country's health care services.

Current estimates place the number of NP's who have graduated from formal programs in the United States at approximately 8,000 (out of a total of approximately one million active RN's in the country today). The number of nurse practitioners who regard themselves as NP's or nurse midwives even though they did not graduate from recognized programs is estimated at 12,000. More than 250 recognized programs, ranging in length from five to fifteen months, are now available, including 13 in New York State alone.

The first nurse practitioner program in the U.S. was established at the University of Colorado in 1965 where the term "nurse practitioner" was coined. Federal legislation and financial support to stimulate the growth of nurse practitioner programs has been ongoing since that time. Currently, "The Nurse Training Act of 1975" (PL-63) provides for a separate program of grants and contracts to meet the cost of projects to "plan, develop, operate, significantly expand or maintain existing programs for the training of nurse practitioners."

The legal definition of the nursing role has also been expanded to facilitate these changes. Since March 1971, 30 states have revised their nurse practice acts to facilitate role expansion for RN's by authorizing diagnosis and treatment. In addition, 12 states have expanded their definitions of professional nursing to include more autonomous functions, especially those of diagnosis and treatment.

Five years ago, the Division of Nursing of the U.S. Department of Health Education and Welfare awarded a contract to the State University of New York at Buffalo to conduct a longitudinal study of nurse practitioners. Phase I of the Buffalo study has now been completed, providing national data on NP programs and students to January, 1974. Findings include:

- Of the 131 educational programs participating in the survey, 86 were certificate programs; 45 were Master's programs.
- Of the students, 98 percent were female; the average age was 35.2 years and candidates had spent an average of 7 years in nursing before entering the program.
- More than half (57.4 percent) of NP graduates were employed by physicians; 80 percent stated that their work was supervised directly by a physician.
- Only about half (54 percent of graduates) used the title nurse practitioner; 18 percent used the title nurse and the remainder titles such as nurse associate, nurse clinician, or nurse midwife.
- Respondents cited "legal barriers" (31 percent) and "resistance from other health professionals" as two important constraints on future development of the NP role.

**Information contained in this report was obtained from an article by Dr. Eugene Levine, chief, Manpower Analysis and Resources Branch, Division of Nursing, Bureau of Health Manpower, Health Resources Administration, Department of Health, Education and Welfare, published in the American Journal of Nursing, November, 1977.*

● New Brunswick

The Faculty of Nursing at the University of New Brunswick supports the idea of preparation and utilization of nurse practitioners. The current curriculum in the B.Sc.N. program is preparing nursing students to be able to function in that role upon graduation.

Dalhousie University in Halifax, N.S. has the only official program for the preparation of nurse practitioners in this region. New Brunswick has not yet employed nurses with the recent specialized preparation from Dalhousie's program.

At present, it is known that there are at least two nurses practising as nurse practitioners in New Brunswick. One is working in a small town with a physician in the area of family practice. The other functions as a nurse practitioner one day per week in a small community; the rest of her time is spent working as a public health nurse.

There are financial problems associated with nursing in all areas of nurse placement and practice in New Brunswick at the moment. There are no signs that any new types of personnel will be assimilated in the near future with the stringent economic situation.

Physicians in this province seem to view the nurse practitioner as something of an economic threat — even as a concept. It seems that physicians are reluctant to refer patients to the home care agency because of some apprehension due to :

1. lack of understanding of the preparation of the nurse practitioner
2. fear of losing control of the care situation, and
3. fear of not being able to charge Medicare for every possible visit of the patient to his office.

● Nova Scotia

A discussion of nurse practitioners or nurses in an expanded role is always difficult because the terms themselves are imprecise.

Dalhousie University in Halifax offers an official program for nurse practitioners and prepares them to work in isolated



Photos courtesy of City of Toronto Department of Public Health and Borough of Scarborough, Board of Health.

northern areas. None of the graduates of the program work in the province of Nova Scotia itself.

One nurse practitioner, a graduate of the McMaster Educational Program for Nurses in Primary Care, is employed at the Isaak Walton Killam Hospital for Children. She is working with a neurologist as the coordinator of a child development clinic. In addition, many VON and public health nurses, who are not graduates of a nurse practitioner program, work in an expanded role. A Report on Nurses in Nova Scotia Performing in an Expanded Role completed in Spring 1975, indicated that 58 nurses worked in an expanded role. They were the initial contact for people entering the health care system and were able to assess the individual's health status and determine the need for medical, nursing or other intervention.

For example, one public health nurse serves a population of 1400 residents of Long and Briar Islands in a mobile nursing station. VON and public health nurses function in an expanded role in medical centers in the communities of Pubnico and Isaac's Harbour. Another works at the family medicine center at Dalhousie University as the community health nurse for the employees. She also assists a family physician in patient care as well as instructing medical students and MDs in community health.

An RNANS task force on the expanded role of the nurse, March 1976-1977, concluded that there was a role for nurse practitioners in Nova Scotia but that opposition by some physicians exists and health services have no monetary mechanism provided for this role.

● Prince Edward Island

At present there are no nurses working in the role of a nurse practitioner in Prince Edward Island.

● Newfoundland

In the academic years 1974-5 and 1975-6 Memorial University of Newfoundland offered a Family Practice Nurse certificate program which was jointly run by the School of Nursing and the Division of Community Medicine in the Faculty of Medicine. The program was funded through a research grant. The research was "To Determine the Impact of a Family Practice Nurse on an Urban Family Practice." In its first year as a pilot program, four family practice nurses were prepared, all of whom returned to rural areas. In the second year, three nurses were prepared for rural areas and seven for the research project. In May 1976 the seven family practice nurses in the project were each attached to a family practitioner, five in St. John's and two in Corner Brook. The attachment was for one year's duration. Since then, the research project has been evaluated and the report is about to be completed.

Since 1976 however, the program has not been offered. The Newfoundland Medical Association states that it consented to the program being given only for the research project and

will not give support to the program until the evaluation is completed. The Newfoundland government also said that it would not sponsor any nurses for 1976-77 in this program, but that does not mean they would never do so.

Currently, there are five family practice nurses working in rural areas and another of that group is now in education. There are, of course, many nurses in rural areas in Newfoundland and Labrador who work in an expanded role. For example, 15 nursing stations in Labrador, run by the International Grenfell Association are staffed by nurses who, due to their isolated circumstances, function as nurse practitioners and who have had some kind of advanced educational preparation in midwifery and outpost nursing. There are also three family practice nurses employed in urban areas. One is working with a family planning clinic; another with a hospital employee health service; and one is in charge of a home for senior citizens. The other four nurses who were attached to physicians are no longer employed as family practice nurses.

In assessing future needs, the School of Nursing has developed a Diploma Program in Outpost Nursing which includes primary care nursing and nurse midwifery skills. A Bachelor of Nursing Program with a major in outpost nursing and nurse midwifery has also been approved. 4





A nurse practitioner at work

What does the term nurse practitioner mean to you? For me, it has always evoked the rather hazy image of a nurse who does things that other nurses don't do. But I certainly didn't feel sure about what those things were, or what made a nurse practitioner different from any other practising nurse. Bonnie Maloney is a nurse practitioner in a busy clinic in downtown Ottawa. I talked to Bonnie to find out what being a nurse practitioner means in day-to-day terms.

Lynda Fitzpatrick

The Sandy Hill Health Centre is a modest flat-roofed building on Friel Street, on the fringes of Ottawa's central core. It has been in operation for two years. The centre is everyone's clinic, the bright waiting room is a study in contrasts — people come in in patches or furs, from babies to senior citizens.

As you walk into the waiting room a large orange welcome sign greets you; there are big plants, and lots of colorful posters of families skiing, skating and winter camping. A large cork bulletin board features lists of local programs and activities. The doctors and nurse practitioners here dress casually and comfortably — there is no sense of white, cool efficiency.

I talked to Bonnie in a tiny cubbyhole that she calls her office. She told me that she first came to the clinic two years ago as a nurse. A graduate of the Ottawa Civic Hospital School of Nursing, she has worked in a variety of settings since 1969, including emergency, intensive care, and doctors' offices. Now, with her own office at the Sandy Hill Health Centre, Bonnie has her own case load, does home visits and has in her own words "a very personal and direct influence on the patients that I see every day."

Back to school

Nurse practitioners may function in very different ways depending on the setting in which they work. And according to Bonnie, it is the team approach at Sandy Hill that makes her role an effective one. Bonnie and Dr. John Molot took McMaster University's Educational Program for Nurses in Primary Care. A strongly cooperative working relationship between a doctor and nurse team is something that is stressed before admission to McMaster's program. If the team relationship is not there, applicants are refused admission to the nine-month course.

When Bonnie and John decided to take the course, the director of the McMaster program, Mona Callin, came to Ottawa to talk to them, to look the clinic over and assess the potential success of the nurse practitioner role in the Sandy Hill setting. McMaster's program is not just a course for the would-be nurse practitioner; it is set up to involve the doctor too. The doctor must first of all be willing to sponsor the nurse for the program. He must also be willing to work closely with the nurse throughout the program, teaching her specific skills, and then working with her for a year following completion of the course.

Bonnie's course, beginning in

September of 1976 and ending in May 1977, was intensive, and demanded all her energy throughout its duration. Class time ran from nine to five, but most of her evenings from six to eleven involved solid library study.

There was a great deal to learn — physical assessment and examination, differential diagnosis and treatment, interviewing and communication skills — with a strong emphasis on a practical approach.

After five months of the course, Bonnie returned to her clinical setting in Sandy Hill, where she was taught by John and worked very closely with him. There were still trips to McMaster, but these would be followed by clinical experience at the Sandy Hill clinic.

During this time, Mona Callin made frequent visits to Ottawa to see how Bonnie was progressing. As Bonnie examined each patient, Mona would sit in a tiny corner of her office watching, listening and writing. Following patient contacts, Mona would share her observations with Bonnie, and together they would evaluate patients she had seen and how she had managed them. There were also frequent meetings between Mona, Bonnie and John to assess the progress of the project.

Bonnie has worked as a nurse practitioner at Sandy Hill Health Centre since

June 1, 1977. During the first month, she worked very closely with John. Since then she has carried her own case load of patients, examining, treating them and providing follow-up care. Because of the way in which McMaster's program is structured, John knows exactly what Bonnie can and does do. When Bonnie runs into problems, she talks them over with John and Jane Diceman, the other nurse practitioner at the clinic. From these discussions, Bonnie goes on to make her own decisions regarding the patient's diagnosis and treatment.

Bonnie says that a program involving both the doctor and the nurse is an important key to the success of the nurse practitioner role. "It enables each member of the team to know exactly what their responsibilities are, it builds trust, and it strengthens the team approach so necessary to the success of our clinic. For me to work successfully and independently, it is important that the doctor knows what I can do, and has faith in what I do."

A work day

Bonnie works a four-day week, beginning at nine a.m. and ending when her work is finished. She also works one evening a week and is on 24-hour-call whenever necessary. What she does at work depends largely on who comes in to the clinic. But whatever the patient's problem, the focus of treatment at Sandy Hill is on health teaching and especially *preventive* health teaching.

"I've had so many people coming in because they've had colds for a year and they can't figure out why. After a full assessment, the reason usually becomes pretty clear. Their nutritional status is terrible — they've cut out good food because they want to stay skinny. They don't do any exercise. They smoke two packs a day. They wonder why their bodies give up — but they don't realize that they've been abusing them."

Or mothers come in with their first babies "and the mothers are having a horrendous time. They're having trouble keeping up the image of the perfect little lady with the perfect baby and the perfect house — you know — the T.V. image. They aren't doing anything for themselves and they need to talk it over."

Assessment

Bonnie books a full hour for the physical assessment of a patient. The length of time is important, because it allows a full examination, allows patients to express themselves, and it provides the opportunity for Bonnie to do some health teaching. During the hour, the patient gets a thorough going over, with teaching along the way.

Bonnie begins by taking a complete family history, writing out a chart to share with the patient later on for some personalized health teaching. She reviews with the patient a health history of parents, grandparents, aunts, uncles and siblings, and ties it in with the patient's own health patterns.



From there, Bonnie goes on to the patient's personal health history: allergies, chronic diseases, immunization record, hospitalizations, fractures, menstrual history, childhood diseases, diet, exercise pattern, alcohol intake and cigarette consumption. She also finds out about the patient's social history, education and job pattern.

Then comes a complete head to toe physical examination. Bonnie takes a thorough look at the patient's eyes, ears, nose, mouth and throat and checks lymph glands. She does a breast examination for women. She also asks every female patient if she does a breast self examination once a month — if the answer is no, Bonnie teaches her why it is important for her to do so. Then she teaches the patient how to do a breast examination, and watches the patient do it, to make sure that she knows how to do it correctly.

She listens to the patient's chest, heart, and abdomen, palpates the patient's abdomen and does a gynecological exam (including Pap test) for women. A check of reflexes and pulses is followed by neurological testing. The patient is asked to walk across the room so that Bonnie can check for minor back deformities that may not have been caught previously.

Talking it over

Bonnie uses each step of the examination to teach the patient something about himself and the care of his body. After a complete physical assessment, the patient gets dressed and sits down for a talk with her. In this time, Bonnie goes over the most important health teaching areas for that particular patient. First, she reviews the patient's family history with him, bringing out its meaning for his own health. For example, if there is a marked incidence of heart disease or circulatory problems in the patient's family Bonnie talks to the patient about what steps he can take now to prevent such problems for himself. If there is a high incidence of cancer, or alcohol abuse, Bonnie discusses the ramifications of these problems for the patient himself. If he requires immunizations, Bonnie talks about why he needs them, and the patient updates his immunizations.

A woman may need to know more about her method of birth control. For example, she may need to talk about the side effects of the pill or the necessity for checking an I.U.D. after each menstrual period.

Bonnie reviews the patient's diet with him — what's good about it, what's not so good, and what he can do about it. And she is a fanatic (her own word) about exercise, aerobic exercise for strengthening heart and lungs. For those who don't have an exercise pattern, she recommends a book called *The Aerobics Way*.¹ If the patient is not likely to read the book, Bonnie tells him to alternate running and walking for half an hour at least three times a week. She also adds that this will feel pretty awful at first, but that later on, the patient will miss it if he doesn't do it.

For smokers, Bonnie has strong advice



— if you smoke, quit. No cutting down. Hide your ashtrays, and don't go where people smoke. Cut out coffee, alcohol and certain social activities if necessary, but don't smoke. Bonnie also tells smokers about clinics that they can attend if they feel that outside support is necessary.

So if you go to Sandy Hill Health Centre for a complete physical, you get just that. And together with Bonnie, you take a good long look at your body and your health patterns.

Patient contacts

Patients also come to Bonnie with very specific health problems. Her daily schedule reads much like that of a busy general practitioner and each day brings its own unique problems. Bonnie sees patients with upper respiratory infections, abdominal pain, gastrointestinal problems, depression, back trouble, unwanted pregnancies, transient ischemic attacks ... the list is as endless as the number of different problems people encounter. And each patient receives

individualized attention to his or her particular problem.

Nancy R. a twenty-two-year old secretary, came to see Bonnie with a common complaint — she felt tired, in her words "all the time." Her physical examination and blood work revealed no physical basis for her feeling of fatigue, but she complained that she'd arrive home from work "just beat."

After receiving Nancy's blood results, Bonnie called Nancy back to her office for a talk. Nancy had been married for six months, she and her husband had bought a house, and she had changed jobs just after her marriage.

Bonnie helped Nancy to take a look at all these changes and see that there was a lot of stress involved in them, — that her response to the stress was fatigue. Together, they explored ways to help Nancy deal with the stresses that she had undergone. Just talking about those changes helped, and learning some new exercise routines and relaxation techniques helped even more.

Jim B. was a construction worker who decided one day that he needed to have a complete physical examination. At thirty-two, he was a well-built individual who appeared very fit. He was also a very chatty individual, friendly, and didn't stop talking from the time he entered Bonnie's office until he left. Bonnie's examination revealed that Jim was borderline hypertensive. After blood pressure checks on three different occasions, Bonnie called Jim back to her office.

She explained to Jim that although he seemed physically fit, his blood pressure bordered on hypertensive. She also explained that if he didn't do something about it now, he would be taking a pill a day by the time he was fifty years old, and that his high blood pressure could contribute to problems with other organs in his body.

What could Jim do about his problem in the present to prevent further problems in the future? After talking for awhile, Jim admitted that he had big problems relaxing. Bonnie showed him that he didn't really do any exercise other than the exercise he got through his job. She encouraged him to take a good look at the pace of his life and the factors that contributed to his feelings of tension. Jim learned some relaxation techniques, and Bonnie talked to him about the positive effects of daily jogging. After two months on an exercise program, Jim's BP was down to normal and he was much more aware of himself and his health. He still drops into the clinic for BP checks periodically.

Jennifer L., an 18-year-old girl visited Bonnie for birth control pills. Bonnie began by taking a complete gynecological history with a Pap smear, and talked to Jennifer about the pill and how it works. She also reviewed alternative methods of birth control with Jennifer. The girl's interest prompted Bonnie to recommend that she read *Our Bodies, Ourselves*,² so that she could be more aware of alternatives. She also encouraged Jennifer to talk about her

feelings — how she felt about her body and sexual intercourse. Jennifer, like many others, had never had the opportunity to talk about these feelings openly, and she was able to clear up many "faboos."

Bob W., a twenty-five-year old man came to see Bonnie about a mass in his right inguinal region. His physical examination revealed that he was in good health; he was a very active individual, who took time every day to jog or swim.

Bonnie wasn't too sure about what the mass was, so she discussed Bob's case with John and described her physical findings. Together they talked about the differential diagnosis, such as possible hernia or lymph adenopathy. Then John took time to examine the patient and discuss possible treatment with Bonnie.

So although Bonnie exercises a good deal of freedom in her practice, she is fully aware of her own limitations and consults with John whenever there is the slightest question in her mind. At the same time, the procedure took only five minutes of John's time, leaving him free to care for his own patients. Bob was referred to a surgeon for repair of his hernia.

Bonnie says that there are many opportunities for teaching and counseling. Obesity is a problem that shows up at the clinic regularly. Bonnie keeps a close watch on those patients who come to her for help with a weight reduction program. These patients return to her every two weeks for weight checks and evaluation. "Many people want to see a specialist for this type of problem. If this is the case, then I refer them to a dietitian."

Another resource person at the clinic is a psychologist who visits the centre weekly to talk to patients or families who require in-depth counseling over emotional problems.

When patients can't come to the office, Bonnie visits them at home. This situation arises mainly with elderly patients — like Mrs. Abbey, a 76-year-old woman with arthritis, who had a bad case of the flu this winter, wanted to see someone about it and couldn't get out of the house to do so. There are also individuals that someone in the clinic checks on every few weeks in their homes just to make sure that they are O.K.

Working together

A nurse practitioner's role and the things that she does depend, to a very large extent, on where she works. In Canada, there are nurse practitioners working in clinics, doctors' offices, emergency departments, public health units, and outpost areas; their functions vary widely.

Obviously a strong practical course in primary care nursing helps to make the nurse practitioner worth her salt when she is practising in the community. But Bonnie says that the setting itself has a great deal to do with how well the program works.

The emphasis at Sandy Hill is on preventive medicine, health and awareness as opposed to bandaid treatment. And the

team approach contributes enormously to a healthy attitude.

There are two nurse practitioners working with John at Sandy Hill. Their goals and philosophy help them to work together in a consistent way to help them provide the best health care that they can. That means teaching people about their bodies, how they can become healthy and stay healthy. Patients are followed up consistently — if they are put on medications, they know why, they know how their medications work and they know what side effects to look for.

I talked to John too, to find out what he had to say about working with nurse practitioners. The fact that he works with two nurse practitioners speaks strongly in their favor. Not surprisingly, his reply was very positive.

He said, "If both the doctor and nurse practitioner are aware of her capabilities, the doctor has trust in what the nurse practitioner says, she knows enough to ask for help when she needs it, then the nurse practitioner is a definite asset to a general practice. She takes a large part of the workload. This allows the doctor more time to see patients; the nurse practitioner has more time too. Between them they have more influence on an increased volume of patients."

"At Sandy Hill, this arrangement gives us time for preventive teaching, the only way to help patients become more healthy."

And although patients sometimes find the idea of seeing a nurse practitioner instead of a doctor initially surprising, the attention and time they have with Bonnie soon dissolves their misgivings. "They like the extra time with me ... they get to know me, and know that I know what I'm doing — and that I'll follow them up."

What are the advantages to working with a nurse practitioner? Bonnie's answer is enthusiastic. "I love it. I'm allowed to use my head. I have a direct influence on my patients' well-being, direct contact with families, and it's personal contact. I can follow my patients, know how they are progressing, know what their jobs are, and keep tabs on what is happening to them."

"The set-up here gives us all time, time to talk, time for counseling, time for the patient to learn something about himself and for me to learn about him."

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Photos by Sharon Andrews

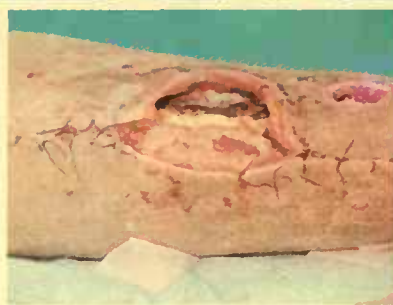
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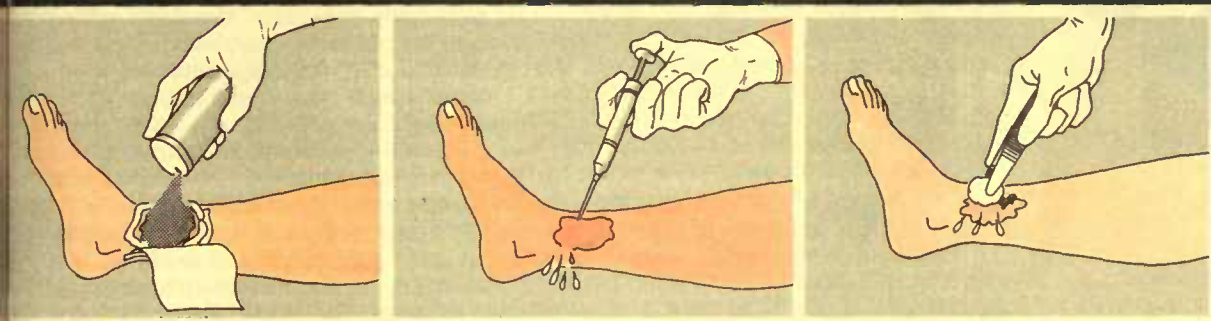
1. Infected exuding ulceration following a tibial fracture.
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3. 21 days. Thirteen days after successful grafting.²

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2. 29 days. The wound culture was negative.
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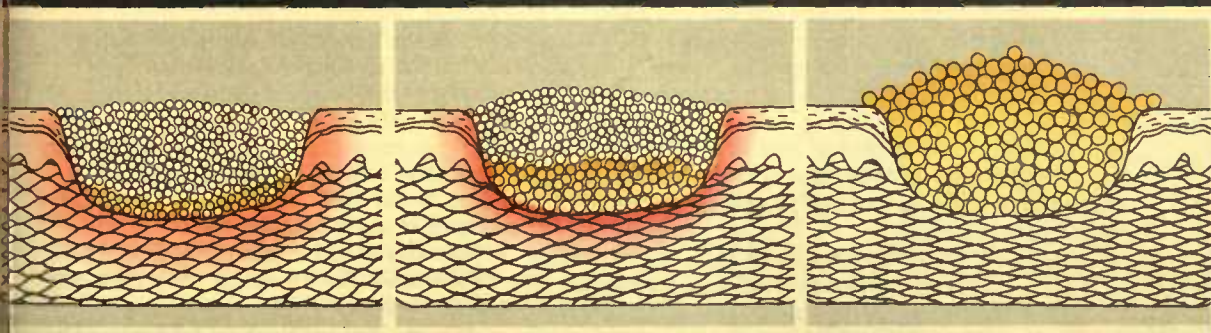
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1. Data on file at Pharmacia (Canada) Ltd.
2. S. Jacobsson et al., Scand J Plast Reconstr Surg 10:65-72, 1976
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ON STRIKE

Josie Makotoko

"I do not say it is good
- I do not say it is bad
I say it the way it is."

Since nursing began, people both inside and outside the profession have equated caring with dedication. Nurses themselves have tended to regard strike action as "unprofessional," "unladylike," even "repugnant." That this attitude is changing is obvious from sporadic newspaper accounts of slowdowns, strikes and lockouts among nurses right across the country. Unions are alive and well and living amongst the nursing profession.

That is "the way it is."

The two obviously relevant variables in this political awakening are the emancipation of women and the relationship between economic and emotional positions. As both the employer and the union familiarize themselves with the law and how it works, they are finding ways of preserving a balance. Each party analyzes its losses and gains, its rights, the do's and don'ts of discipline and methods of fighting this tug-of-war.

This is not an article either supporting or condemning the morality of strikes; it is simply a report on what it is like to be on strike.

A normal working day

There was nothing about the way the day started to indicate to the nurse that this day would be any different from any other. By eight-thirty she was at her desk, sorting through the black tray piled with papers and documents, all demanding immediate action.

Her first job was to sort the day's priorities:

- Those P.K.U. blood drops for the Guthrie test would have to be cleared first. This would serve the double purpose of visiting these mothers and their newborns.
- A rapid class inspection would have to be carried out at a school where scabies had been reported. The inspection would also provide an opportunity for classroom teaching on hygiene and the prevention of communicable diseases. While in the school, there were ten pairs of eyes needing retests and a dozen notices to be sent to the parents of children needing medical attention. Also, the principal had requested some health assessment reports and should be reminded to arrange for a teachers' group meeting and a teacher-nurse conference for the nurse's next visit.

One more glance at the Daily Activity Schedule Sheet to be sure her name was down for the Geriatric Clinic that afternoon. Time was also allotted for the Family Planning and Special Treatment (V.D.) Clinics as well as for the hospital and other liaison programs. Later on, time would have to be found to write up the reports and records of the day's activities and to prepare for the next day's prenatal class.

The day seemed complete. It was time to hit the road. But the usual telephone calls were pouring in:

Mrs. A: "My baby keeps on being sick; it shoots out of the cot." Was it the baby, the nurse wondered, or the sickness. Taking no chances, she decided the doctor would have to sort that one out.

Mrs. B: "My baby won't finish his feed. I don't mind myself, but it's my mother-in-law."

Mr. C: "My wife never sleeps. She talks all night to an invisible man. Do you think she has been cheating on me nurse? She does not allow the children to go to school, either, just in case they miss hearing this man's voice."



Sudbury Star Photo

Mrs. Anonymous Caller: "I don't want to cause no trouble but somebody really ought to go and see those poor little things in the next apartment. They are so hungry, thin, and dirty. The house is a mess and cold. That mother next door is good-for-nothing."

It was a normal day, all right. Perhaps she could re-arrange her schedule a little to accommodate some of the new callers. The nurse did not notice that someone was standing next to her until she heard him say, "Hi!" When she turned around she saw the local union official who announced softly: "Today, in about five minutes, we are withdrawing our services. We are on strike. All the public health nurses and registered nurses."

For a moment the nurse sat there, her mouth gaping, eyes wide, gazing at her cluttered desk and the pile of papers on the black tray, thinking, worrying about all those plans and appointments she had already made for today.

It was true that weeks ago she and all the other nurses, after everything else had failed, has voted 100 percent in favor of strike action against the employer. The dispute centered on their struggle for economic justice. They had worked for almost two years without a contract. But, the Union committee had kept the month, the week, the day and the hour of the strike a big secret, so the announcement took everyone by surprise.

After nine a.m. that beautiful building, their place of employment became "out-of-bounds" for the 60 nurses who worked there. Alas, the "ladies-of-the-lamp" became "street walkers!" Armed with the conviction that if Florence Nightingale had been alive she would have led their parade, they marched with their heads held high.

The strike had begun.

On the picket line

Outside the building, the nurses hoisted their picket signs, each choosing the slogan or phrase that seemed to suit her particular emotions, feelings, and frustrations. The nurses thought they would be doing the things they had seen striking industrial workers do, like barring people from entering the picketed property. They soon realized,

however, that theirs was a "strike with a difference" when they found themselves counseling and teaching health to citizens who still turned to them. University students, anxious to complete their community health projects, headed for the picket line seeking help and advice. One slight, short-statured student had a difficult time keeping up with a tall, well-built public health nurse who carried a "gun" picket while she paced the circuit. Her strides were long, fast, and soldier-like. Left, right; left, right; about turn — left, right. As she marched, the nurse lectured and the student had to literally run to catch her words. Others who had reason to go inside the building were dealt with sympathetically and given the directions they needed.

Walking back and forth, the nurse continued to think about her clients. She worried about the family that was about to be evicted from their house due to rent arrears and about the family whose parents cheerfully reported burning several mattresses because of bed-wetting children. ▷





At the nurse's request, the Salvation Army had supplied new mattresses which, the nurse stressed, must be protected from head to foot and all around with waterproof covers.

Because the war was not against the public, the nurses received overwhelming public support. Passing motorists honked their horns and waved to the picketers, using all kinds of hand signals — the clenched fist denoting power, the V-for-Victory sign with two fingers upraised, etc.

Scores of others came to support the nurses and to picket with them. There were representatives from other unions in the community as well as individuals. The nurse remembered one especially friendly supporter who had evidently spent his day at a local hotel. By the time he reached the picket line he was having difficulty walking; his speech was slurred and he just did not know where home was so he decided the next best place was right there with the "street" girls! When the newspaper and television reporters and photographers arrived to talk to the strikers, he made sure his picture was taken and his story heard too.

Continuing education

The nurses were learning about group dynamics, not from books this time but from a real life situation. Brainstorming sessions were held and members encouraged to voice their thoughts on any matter whatsoever.

This stimulated others to do the same and a variety of ideas became available for consideration. The diversity of thoughts and values gradually gave way to a strongly united agreement on the course to follow.

Conformity on the picket line even extended to the type of clothing the nurses wore and, with the arrival of the cool weather, many husbands witnessed the mysterious disappearance of their warm thermal underwear.

The leaders, the commanders and the captains of the strike organized their forces to make sure that all the borders were well guarded, particularly the notorious jungle up the mountain where illegal infiltrations were reported. Of course, there were hawks, doves and moderates, the three groups essential for equilibrium. Everyone mastered the art of politicking whether they were

making speeches on political platforms, lobbying behind-the-scenes or campaigning underground in order to communicate with the general public and to reach the policy makers.

Not having a baby sitter was no big deal! The nurses simply brought along their children to join them on the picket line. The kids had their outdoor fun while the nurses upgraded their child growth and development education. One young lad asked his mother, "Mum, why don't we have more strikes, we have so much fun here?" Nearby a toddler buried cookies in the sand, dug them out and licked them off before biting in. She looked at the worried adults around her with an innocent little face as if to say, "Can't these women forget about that hygiene stuff while they're on strike?" The "terrible two's" and the other little rebels were eager to go and play inside the restricted building and perhaps to meet the employers face to face. The "trusting three's" and all the faithful stayed closer to mum, carrying their little picket signs to show their solidarity.

The small strike headquarters, donated by a sympathetic citizen, was located conveniently close to the picket line. Plumbing, carpentry, electrical, etc., repairs were often required. Husbands' trousers with many, bulging pockets were handy for carrying tools up to the roof to take care of leaks. One nurse was located with only her back and feet visible because her head and hands were buried inside a tank and toilet bowl while she carried out some necessary repairs. Should anyone need these services, they had better hurry before the nurses become unionized plumbers!

And talk about cooking! There was so much food and everyone ate so much that weight gain and obesity became the strikers' main health problem.

In retrospect

"Nurses Back At Work public health nurses employed with the Sudbury and district unit are back at work again having achieved a salary settlement which places them among the best paid in the province. Registered nurses will now start out at (Sault Ste. Marie Star, Circ. 23,800, December 16, 1977)

Was it all worth it? The nurse hesitates, remembering. Her answer is a qualified "yes."

The nurses feel that the strike brought them credibility and recognition. Communication between the employer and the union is definitely better. And there is a new awareness and acknowledgement of the role of the public health nurse in the community.

Not all of their demands were met. Following the announcement that close to 4,000 workers at the International Nickel Co. (INCO) and Falconbridge Mines were being laid off, the nurses recognized a responsibility to make themselves available to the miners and their families at this time of stress. After all, the miners were there when the nurses needed them.

And that is "the way it was." ♣

Josie Makotoko, (R.N., S.C.M., B.T.A.) the author of "On Strike," practised in a variety of settings in England, Scotland and Africa, before coming to work as a public health nurse in Sudbury, Ontario. She is now working towards her Master's Degree in Health Education at Central Michigan University and was a co-author of "Reproduction and the Test Tube Baby" (CNJ, February, 1977). In the letter that accompanied her original submission, she wrote: "The 60 Sudbury nurses of the Ontario Nurses Association, Local 87, would like to share their experiences with nurses all across the country, many of whom have written to ask us what it's like to be a nurse on strike. This article is written for them. This is "the way it was."

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do I still care?

Linda Sklar-Mathie

How often do you leave work feeling dissatisfied and cheated? Not long ago, I noticed that more and more, this was the way I felt. One morning riding home on the bus after a busy, twelve-hour night shift, I finally realized that it was time to get down to the roots of these feelings.

I seemed to be following the path of so many of my colleagues who grumble about nothing in particular and yet never look for a solution. Besides, I really had no reason to grumble anymore. I had just returned from a six-month holiday and transferred to a new hospital. My first impressions of that hospital were very favorable: cooperative staff/ administrative relations; good working hours; friendly atmosphere; and, above all, the patient, not the budget, came first. What more could I ask for? And yet, my feelings of dissatisfaction continued.

Thinking back to my school days, my feelings certainly were different then. I had wanted to be a nurse since I was about six years old, so entering training was a dream come true. The knowledge I acquired excited me and I was eager to apply it. There were so many new situations to deal with: coping with families and doctors; learning new procedures; organizing my workload; teamwork; handling and being responsible for drugs. Our minds were constantly being challenged. We had excellent instructors who taught us in class and on the wards. Doctors seemed to go out of their way to explain things to us. Every second or third month, we changed wards and learned about another area of nursing.

For many of us, it was our first time away from home. Most of us were responsible enough for our age, but our circle of acquaintances had been small: school chums, church groups, our families. As a rule, we knew everyone in that sphere fairly well, knew what to expect of them and them of us. We were not used to dealing constantly with total strangers like our patients on a very personal, intimate basis. We were surprised that these strangers confided in us, often many years their junior just because we bore the title of *student nurse*. I, for one, took this new responsibility to heart. I was constantly trying to know my patients better; to appreciate their fears and anxieties; to know of any problems that could be bothering them. As often as not, I'd end up going home as upset about something as my patient.



Photo courtesy of Winnipeg Health Sciences Centre

Angels of mercy

At first, I put the graduate nurses I worked with on a pedestal. I saw them all as kind, ministering angels of mercy but, as time wore on, I saw them much more realistically. Some continued to help me keep faith in nursing. They seemed to be kind, considerate, sincere people. Like me, they had bad days but they were essentially sincere. Others appeared hard and callous. They talked about a patient as if he were a number, not a person with feelings. Often, they seemed lazy, sending me in to deal with their patients while they sat at the desk talking. What appalled me most was the reaction of many of these nurses to the death of a patient, as if it were of no consequence whatsoever. I swore that I would *never* be like these nurses.

Well, graduation came, and I was on my own, out to prove what a good, kind, sacred profession nursing could be, especially when I was the nurse involved.

I worked briefly in a pediatric unit in a small hospital in northern Canada. Most of my patients were tiny tots less than a year old. Many were Indians and Inuit flown in from hundreds of miles away, so I had few families to deal with. The children weren't old enough to carry on a conversation so my nurse-patient communication lines didn't improve. However, I loved them all, weeping for the dying ones and laughing with the healthy ones. This, for me, was nursing as it was meant to be — *caring*.

Ever since then, I have worked in Intensive Care. I found the first unit I worked in very exciting with so many new things to learn and so much added responsibility. Unbeknownst to me, however, as time went by my "person" care started to deteriorate, just like the graduates I condemned so much in training. Oh, my nursing care was fine. I paid careful attention to all the minute details so important in an I.C.U. The patient in bed 72 with the bad chest got suctioned q2h; got turned q2h; his Ampicillin was given at 0600 hours, 1200 hours, 1800 hours, and 2400 hours. So many of the patients were intubated or unconscious that at times the only other people to talk to were other staff members.

Does the following scene sound familiar? Two graduate nurses go into Mr. Smith's room to suction and turn him. One nurse explains very briefly to Mr. Smith, an intubated, acutely ill patient, what is to be

done. Then, the whole time they are in with him doing his nursing care, they talk about their new boyfriend or their weekend off, as if Mr. Smith were totally incapable of understanding. They completely ignore the fact that he may want to try to communicate in a non-verbal manner about some problem or anxiety.

I started to become extremely impatient with any patient who didn't conform to my idea of how he should behave, like Mrs. White, for example, the lady in bed 74. She had had a thoracotomy and was doing fairly well. She could have Demerol every four hours but became extremely agitated after only two hours and would insist that she needed more analgesic. I would try to explain, rather impatiently, that I couldn't possibly give her more until the four hours were up as ordered by the doctor. Instead of staying and trying to reassure her or find if she had some hidden fear that was agitating her, I would go out and complain to my co-workers about what a difficult patient she was becoming.

My interest in acquiring knowledge seemed to be decreasing. When I started, I always found time to question doctors about conditions or expected outcomes. Now I was no longer doing that. If a particular doctor had a patient in the unit, I would follow his standard procedures. Even if I didn't think one of his procedures beneficial to the patient, I no longer commented on it, but carried it out "as ordered."

Shift work started to interfere with my blooming social life. Now that I was earning money, I wanted to spend it. Most of the time, the person I wanted to spend it with was working different hours from my own. After three years of intensive care nursing, I decided that I had had enough of sick people, hard work, and irregular hours; I took a six-month holiday.

Now, here I was again, sitting on the bus, almost too tired to move and feeling much the same as when I'd left six months ago.

Why? Why do I feel so dissatisfied with nursing, I asked myself? The patient I'd had that night, Mr. Johnson, had been an older gentleman with a chronic chest condition. He was confused and restless and had frustrated me enormously by tugging at his tubes, trying to crawl out of bed, and calling out for a long-dead brother. Even his daughter, who came to visit him several

times that night, couldn't reorient him and get him to settle down.

Then it struck me — *people!* That was the answer. I had turned into one of those nurses who no longer respond to people, just their condition. Mr. Johnson was a prime example. His daughter had spoken to me of her father. Normally, he was a very kind person with a terrific sense of humor. "Yes, yes," I'd thought, "that's all very well, but it doesn't help me now." And there it was. I no longer cared about the person and his feelings, just his condition and the expected outcome.

Total patient care

I was disturbed: did I really care enough about the person I was nursing to give *good* total patient care? What exactly does caring mean? According to Webster's World Dictionary, it means to be worried, to be concerned. I asked myself whether I was really concerned about all my patient's needs — physical, mental and social — and had to admit I really didn't know. I realized that I'd been blocking out the patient's personality for so long that it would take close scrutiny of my feelings and actions to come up with an answer.

Is caring absolutely essential to nursing, was my first question. In our society, there are many jobs where no caring is involved. Many people work their eight hours, often with inanimate objects, make X number of dollars, and go home. They are not required to spend a great deal of energy on concern or caring for fellow workers or customers. Their awareness of human feelings and emotions is not caught up in the tasks that they perform. They can save their feelings for the time they spend with the people who are closest to them.

In nursing, however, our prime commodity is *people*. Although certain procedures, techniques and assumptions are fundamental to nursing practice, their application can never take place in a vacuum. People are individuals and react in individual ways to the nursing care that they receive. When they are well, people seem to think, "I'll never get sick. Sickness is something that only happens to the next guy." As a result, when they enter a hospital, it's a totally new, unexpected, frightening world where they no longer control their own lives. No matter how minor the problem, they are suddenly faced with feelings they do not

have to contend with in everyday life. New fears crop up: fear of permanent damage; fear of mutilation; fear of sudden debilitation. How long will I have to be off work? Will I be able to meet my bill payments? Will I be able to carry on my usual activities after? Worst of all is the fear of death. Our society seems to cringe away from the very thought of death and dying. Few people I've talked to in the hospital had ever thought much about dying, or come to terms with their own death before becoming ill.

In order to deal with all these feelings, nurses must have their own emotions under control. They must know what they feel about life, and how they want to live their own lives. As human beings, however, nurses also go through periods of stress. At such times, it is difficult to leave one's problems at home. When her own problems weigh heavily on her mind, a nurse may find she has less of herself to give to the patient.

The wall

Looking back, I had started to build a wall-like barrier between myself and my patients at a time when my personal life was in a state of upheaval. Often during this year, I had great difficulty in forgetting my personal problems while at work. I felt distant and cool with patients. I became agitated if they tried to tell me about their fears and problems since I felt I had too many of my own. Eventually, however, my personal life sorted itself out but *the wall* persisted. It had become a habit that I didn't even notice — until now, that is.

Thus it was that I set out with renewed interest to see if indeed I did still care. In the process, I found myself becoming much more attentive to patients' needs and wants. Through normal conversation, I found out so much about a person. I found I could once more be lighthearted with people, which in turn helped to boost the spirits of some patients. When a patient came to me with a very serious, worrying question about his condition, I found myself relating to that person as a *person*, rather than as nurse to patient. Routines became less important; I tried to fit procedures into the patient's schedule, rather than fit the patient into the procedure schedule. Once again I became aware of cultural differences and how these affect a patient's hospital conduct. Often, patients expressed appreciation for something I had done, making me aware that

I was giving without having to force myself. Relating to people was becoming easier and much more natural.

This was progress, I felt, but I still wasn't convinced that I really cared. It is relatively easy to relate to patients whose return to health is a tangible expression of the results of your care, especially if they say "thank you" now and then. But what about the patient who isn't going to recover? Was I enough of a person to feel sorrow for a person I didn't know very well? I soon had a chance to find out. On one particular midnight shift, I nursed a middle-aged lady who was bleeding profusely post-operatively. The woman was on a respirator and had to rely on eye movements and hand grips to communicate but we managed to understand each other. Her family came in to visit often that night for brief periods and through them I was able to know the patient a bit better. She was a woman who had much to live for: a loving family and a rewarding career. Her condition worsened, and by five o'clock in the morning the medical team realized there was no hope. By six o'clock she was no longer conscious or responding so all we could do was comfort and prepare the family. As I went off-duty that morning a family member came up to thank me for "caring about our mother."

I phoned the hospital later that day to find that the lady had died at mid-morning. Knowing that her life was finished made me sad: no more walks in the park with her grandchildren, no more Sunday dinners with the family. She had truly enjoyed her life and at that moment, I felt great sorrow for the family who would remember and miss her.

That day I realized that I do still care for people. I am willing to give of myself to my patients. I know my limitations, though, and I have no notion of becoming a "Wonder Woman in White" to all of my patients. But I *can* relate to them as one feeling being to another. I'll listen when they need to talk; I'll share my professional knowledge, I'll laugh with them and I'll cry with them.

I still care. Do you? 🐾

Linda Sklar-Mathie, author of "Do I still care?", describes herself as a practising registered nurse who writes in her spare time. A graduate of the University of Alberta Hospital school of nursing, she is presently employed as an RN in the Intensive Care Unit of St. Paul's Hospital in Vancouver.

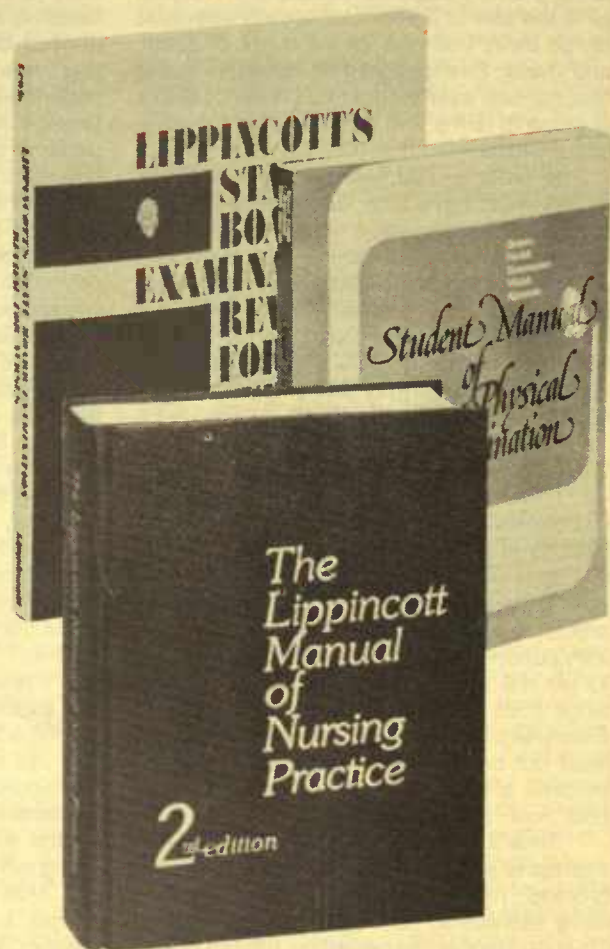


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By LuVerne Wolff Lewis, R.N., M.A.
Lippincott. 745 pages, plus answer sheets/
January 1978/paperbound, \$12.75.



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This excellent student manual covers physical examination of both adults and children and is correlated with selected texts and films dealing with the subject. The manual's format allows the student to do much preliminary work independently, thereby conserving the instructor's time. Individual sections on specific parts of the physical examination are similar in format and are divided into areas that deal with *basic knowledge, inspection, palpation, percussion, and auscultation*. Each general area

contains the following features: behavioral objectives, learning objectives, labeling of diagrams, questions, and physical exam checklists. A self-evaluation key appears at the end of each unit, so that students can monitor their own progress.

By Marie Scott Brown, R.N., M.S., Ph.D.; Carolyn M. Hudak, R.N., M.S.; Janice Brennehan, R.N., M.S.; Kathleen A. Walsh, R.N., M.S.N.; and Karen M. Kleeman, R.N., M.S.
Lippincott. 251 pages/1977/paperbound, \$8.90

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6. **Patient teaching considerations** for most clinical conditions are listed alphabetically in the opening pages of the text.
7. **Hundreds of illustrations** depict the highlights of treatment and nursing management (over 100 illustrations are new).

By Lillian Sholtis Brunner, R.N., B.S., M.S.N.; and
Doris Smith Suddarth, R.N., B.S.N.E., M.S.N.
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A look at how your national association operates, the people who direct it and how they are elected to office.

This is YOUR Association!

Joan Gilchrist

In March, CNA's director of administrative services, Beryl Darling, outlined some of the basic facts about the financial operations of your national association and the services to which you are entitled as a result of your membership in CNA.

In this "convention issue," I would like to introduce you to the 27 nurses who have allowed their names to stand for election to your 1978-80 executive committee of CNA. On the next nine pages, you will find a brief biographical sketch, a photo and statement of their intentions from each of these candidates.

If you plan to attend the CNA convention, you will have the opportunity of meeting these candidates and, if you are a voting delegate, of helping to determine which of them will fill each of the elected offices during the next biennium. But, whether or not you actually have the chance to vote, it is important that you, as a member of CNA, understand the procedure that is involved and what these people, as your elected representatives, will be doing for you and for the nursing profession over the next two years.

Here then are some of the questions (and answers) that you may have about the way your association operates.

1. What are the offices that these candidates are running for?

The president, president-elect, first and second vice-president and five members-at-large are all elected officers of CNA. Except for the president (who automatically assumes that office at the conclusion of her term of office as president-elect) they are elected for a two-year term by the voting delegates at every second annual meeting. Together, they constitute what is known as the executive committee of CNA.

2. What is the difference between the executive committee and the board of directors?

There are 20 nurses on the CNA board of directors — nine elected officers and one representative (usually the president) from each of the eleven provincial/territorial

Table one

Voting delegates by province, 1978 annual meeting

	CNA members 31 Dec. 1977	First 500	Second 500	Additional 500	Votes
B.C.	16,629	3	2	31	36
Alta.	12,518	3	2	23	28
Sask.	7,169	3	2	12	17
Manitoba	7,468	3	2	12	17
Ontario	18,750	3	2	35	40
Quebec	44,213	3	2	86	91
N.B.	4,723	3	2	7	12
N.S.	6,338	3	2	10	15
P.E.I.	942	3	—	—	3
Nfld.	3,521	3	2	5	10
N.W.T.	195	3	—	—	3
Total					272

member associations. In addition, each director from a member association is entitled to be accompanied at board meetings by an adviser. This adviser, usually the executive-secretary/ director of that provincial/territorial association, attends in a non-voting capacity.

Directors meet two or three times annually and are responsible for establishing and revising association policies, reporting to the membership at annual meetings and generally acting to make sure that the objectives of the association are achieved.

The executive committee, on the other hand, meets more frequently and is responsible for administering the affairs of the association between meetings of the board of directors.

3. What are the specific functions of the members of the executive committee?

The board of directors has delegated three specific functions to the executive committee:

1. finance
 2. legislation
 3. program planning for annual meetings.
- In addition, all of the elected officers work together to develop and subsequently propose specific goals and priorities for the board during their term of office. These are then discussed at a board meeting and final decisions are made.

They also screen and develop project proposals and assist in the identification of experts in various areas for representation on a variety of task forces, panels, etc.

4. Do the five members-at-large have a specific role?

These elected officers each bring a national perspective and their own special expertise to the deliberations of the board. They are expected to be knowledgeable about current trends and problems and to express these concerns to the other directors so that the association's policies and programs will reflect what is actually happening in the fields of nursing administration, education, practice, research, social and economic welfare.

5. How are the candidates for these elected offices chosen? Could I or one of my friends be a candidate?

The names that you see on the ticket of nominations have been submitted to the committee on nominations by the eleven CNA member associations. Each association is allowed to submit one candidate for each elected position.

Any individual member-in-good-standing of a provincial/territorial member association is eligible for nomination by either his/her own association or any of the other ten provinces/territories. Although many of the candidates, particularly for the office of member-at-large, are "experts in their field," expertise and academic qualifications are not as important in the selection of candidates as the commitment of the individual to the challenge of decision-making at the national level.

Convention note

A change in plans has forced Dr. David Suzuki, who had previously agreed to address an open meeting during the CNA convention, to cancel this engagement. Instead, CNA members and guests are invited to hear Roy Bonisteel, well-known TV personality and host of CBC's "Man Alive," who will be guest speaker at a public lecture on Tuesday evening, June 27th. His topic will be "The frontiers of science and humanity."

6. Can a person be elected to office if his/her name does not appear on the ticket of nominations?

Yes, any voting delegate at an annual meeting where an election of officers is being conducted may nominate a candidate for any office as long as he/she has the written consent of that nominee.

7. Who gets to vote on the ticket of nominations?

Voting delegates are named by the member associations. Each of the eleven associations is allowed a certain number of delegates according to the size of its membership. (See Table one) Voting delegates vote by secret ballot on the ticket of nominations and they are also eligible to vote on resolutions and motions that arise during the annual meeting.

8. Is there any way that I, as an individual "grassroots" member, can become involved in what goes on at the national level?

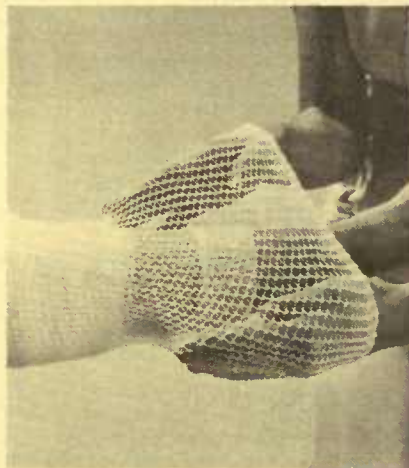
That's exactly where you should begin... at the "grassroots". Start off by becoming involved with the affairs of your own provincial association. Accept responsibility at the chapter level and get to know the people and problems at that level. After that, you're ready for the challenge of participation in provincial and, eventually, national, policy-making. Remember, there's lots of room at the top for the individual nurse who really believes in her profession and helping her fellow nurses to get ahead.



Joan Gilchrist is the retiring president of the CNA. Director of the school of nursing at McGill University, she assumed the office of president in June, 1976.

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CANADIAN NURSES ASSOCIATION

TICKET OF NOMINATIONS ● 1978-80 Mandate

President Elect
(1 to be elected)

● Shirley Stinson

Vice-Presidents
(2 to be elected)

● Myrtle Crawford
● Helen Niskala
● Sheila O'Neill

Member-At-Large,
Nursing Administration
(1 to be elected)

● Sister Bernadette Bezaire
● Mary MacInnis
● Kathleen McCutcheon
● Ginette Rodger
● Sheila Stewart

Member-At-Large,
Nursing Education
(1 to be elected)

● Shirley Alcoe
● Norma Fulton
● Jane Haliburton
● Margaret McCrady
● Margaret Neylan
● Amy Zelmer

Member-At-Large,
Nursing Practice
(1 to be elected)

● Betty Lethbridge
● Karen Mills
● Thérèse Schnurr

Member-At-Large,
Nursing Research
(1 to be elected)

● Janet Kerr
● Odile Larose
● Ruth MacKay
● Annette Stark

Member-At-Large
Social and Economic Welfare
(1 to be elected)

● Margaret Bentley
● Linda Gosselin
● Anne Toupin

Committee on Nominations
(3 to be elected)

● Laura Butler
● Sister Barbara Muldoon

President



Helen Taylor, B.N., M.Sc.(A)
(McGill U.), Diploma in Teaching
and Supervision, (McGill U.)

Present Position:
Director of Nursing, Montreal
General Hospital

Association Activities:
CNA — President-elect (1976-78);
Canadian Council on Hospital
Accreditation - chairman of the board
of directors; Canadian Nurses
Foundation - former president; ONQ
- former first and second
vice-president, president and
member of Committee on
Management.

The strength of a professional
association is contingent upon its
members for it is the membership
which shapes the direction of the
organization. The Canadian Nurses
Association has endeavored to
respond to current issues which
nurses have identified and to develop
policies and programs which
demonstrate its responsiveness to
health care needs of the population.

There is a need to continually
reassess established priorities to be
certain goals are clear and that our
programs are both practical and
relevant to the ever changing times. In
our efforts to influence the health
status of Canadians we must be
prepared to critically examine our
educational structures, our systems
and methods of providing care, and
we must also recognize our
professional responsibilities
concerning important social issues of
the day.

During the next biennium your
association will continue to support
the projects and programs which have
been initiated and are at various
stages of development. These will
include a definition of nursing practice
and development of standards of
nursing practice. Work on the
comprehensive examination for
licensing will continue and the newly
established Labor Relations
consultation service at CNA will be

given every possible assistance to
enable it to meet the needs of our
members.

The promotion of nursing
research and opportunities for
advanced study for nurses will receive
close attention in the months ahead,
and cooperative action with other
groups will be emphasized.

During the next biennium we will
endeavor to represent our profession
where decisions are made which
could affect nursing and the health of
our population.

Candidate: President elect



**Shirley M. Stinson, B.Sc.N., (U. of
Alberta), M.N.A. (U. of Minnesota),
Ed. D. (Columbia U.)**

Present Position:
Professor, Faculty of Nursing and
Division of Health Services
Administration, U. of Alberta,
Edmonton

Association Activities:
CNA — 1st vice-president (1976-78),
member-at-large for nursing
education (1974-76), chairman
(1971-73) and member (1972-76) of
special committee on nursing
research; AARN - member of
committee on nursing research
(1973-77) member of ad hoc
committee on the Chichak Report
(1971-72); member of health
committee of the Economic Council
of Canada health services committee
(1973-74); author of numerous
articles and reports.

The CNA is a federation of
autonomous provincial and territorial
nursing associations. As such, it is
not our "boss"; rather it is *ourselves*
and *our instrument*. The presidential
leadership style required in this type
of organization is not that of the
despot, the single-minded crusader,
nor is it that of the laissez-faire
custodian. What is required is
leadership which facilitates frank

discussion and the development of
incisive and practical approaches to
matters of national concern, and
which engenders vision and courage.
It is this type of leadership that I
would strive to provide.

Candidates: Vice-president



**Myrtle E. Crawford, B.S.N. (U. of
Saskatchewan), M.A. (Columbia
U.)**

Present Position: Assistant Dean,
College of Nursing, U. of
Saskatchewan, Saskatoon,
Saskatchewan.

Association Activities:
CNA — member of the board
(1963-65) and past member of
several committees; SRNA -
consultant to committee on
legislation and by-laws (1974-77),
president (1963-65); member of U. of
Saskatchewan Senate (1962-68);
chairman (1976-77) and member
since 1973 of joint committee on the
Saskatchewan nurse-practitioner
demonstration project; member
(1974-) of board of nursing
education, Saskatchewan
Department of Continuing Education.

Nursing is at a crossroads in its
progress as a profession. The
national association has a significant
role in determining the future
direction of the profession. Policies
and positions established by the
CNA will influence other
associations, health care agencies,
and governments. I believe that I
have had a number of experiences
that have prepared me to take part in
shaping these policies. Nurses
speaking through their professional
associations should take positions on
many of the sensitive health-related
issues of today. Too often we have
held back from making our views
known and have only responded
when prodded by some outside
agency. In some situations we
should be acting rather than reacting.
I would hope that 1978-80 would be
a very active biennium for the
Canadian Nurses Association.



**Helen Niskala, B.N. (McGill U.),
M.Sc.N. (U. of California, San
Francisco), Ed. D. (U. of British
Columbia)**

Present Position:
Director, Education Services,
Registered Psychiatric Nurses
Association of B.C., Burnaby, B.C.

Association Activities:
RNABC — member of community
mental health quality assurance
workshop committee (1977-),
committee on nursing education
(1976-77), committee on approval
schools of nursing (1976-), roles and
functions task committee (1976-77)
and committee to joint Health
Department/RNABC study on
psychiatric nursing consultation
(1976-), member of the board of
directors (1970-72); AARN —
member of nursing education
planning committee (1973-75); has
also served on many other
committees and published numerous
articles.

I consider a position on the board of
the national association challenging
because I feel that the Canadian
Nurses Association has a vital and
critical role to play as a
spokesperson for our profession. The
Canadian Nurses Association can
use the collective political strength of
Canadian nurses to influence health
care planning and public policy, to
deal with increasing government
intervention in nursing affairs, and to
capitalize on increasing consumer
involvement. As an individual deeply
concerned about the practice of
nursing, and one who has practiced
nursing at various levels and in
several provinces, I will try to use my
understanding of the regional
differences and, at the same time,
the common problems faced by
nurses trying to improve the health
care of Canadians. If elected to the
board of the Canadian Nurses
Association, I am willing to serve for
a two-year term.



Sheila O'Neill, B.N. (McGill U.), completing M.Sc. in nursing at McGill University

Present Position:

Nursing Director, Medical Pavilion, Royal Victoria Hospital, Montreal

Association Activities:

CNA — 2nd vice-president (1976-78), past member of board of directors as non-voting observer, past member of committee on social and economic welfare; ONQ — member of bureau (1968-76), 1st vice-president (1970-74), member of task forces on bills 65, 250, and 273, co-chairman of professional services committee.

I believe wholeheartedly in nursing as a profession, with all of the commitments to continued learning, development, self-discipline and public responsibility that that word entails.

The CNA provides the forum where nurses from every part of the country share the realities of nursing and the health care field today, and can search for creative responses to tomorrow's challenges.

I have accepted this nomination because I would like to continue to be part of that process.

**Candidates:
Member-at-large,
Nursing
Administration**



Sister Bernadette Bezaire, R.N. (Holy Cross Hospital, Calgary), B.Sc.N. (Boston College)

Present Position:

Until recently Director of Nursing, St. Paul's Hospital (Grey Nuns'), Saskatoon, Saskatchewan

Association Activities:

SRNA — member of council (1971-77), representative on Senate of U. of Saskatchewan (1974-), chairperson of committee on chapters (2 yrs), 1st vice-president and chairperson of committee on registration and admission to membership (4 yrs.); past president of Catholic Hospital Conference of Alberta.

I believe that, like the Gospel message, nursing administration is a creative work.

I believe that we have first to give it shape in our own life by reconciling our methods and behavior with what we profess to believe about nursing, about management and about the value of human life. In other words,

I believe that nursing administration requires a constant striving, to ordain 'the means to the end' in an orderly and preconceived fashion. The end must always be a selfless caring for people — both for the ill and for those with whom we interact in the course of our duties.

I believe that nursing's unique contribution to the health care field will be achieved every bit as much through inspiration as through constant struggles to persuade others of the importance of our role.

I believe that the Canadian Nurses Association is the appropriate vehicle to help nursing administrators across Canada to develop this potential. I would feel privileged to assist in the realization of this challenge.



Mary Elizabeth MacInnis, R.N. (Kingston General Hospital), Diploma Nursing Service Administration (U. of Western Ontario), B.Sc.N. (U. of Western Ontario)

Present Position:

Vice-president, Nursing, Victoria Hospital Corporation, London, Ont.

Association Activities:

RNAO- chairman of provincial administrative committee (1976-78); OHA - member of the labor relations committee; Nursing Sisters' Association of Canada (London Unit)-president (1977).

I have accepted the nomination for the office of member-at-large nursing administration as I am interested in the total picture of nursing in Canada and most particularly that of nursing administration.

At this time, I am responsible for the department of nursing in one of the largest hospital health-care centers in Canada. I am very personally involved in nursing administration at this local level.

I have been chairman of the provincial administrative committee for the Registered Nurses Association of Ontario for the last two years. This has been an interesting and informative experience. In this period I have become involved in the concerns of nurse administrators in Ontario.

I would now like to become involved in the activities and concerns of nurse administrators across Canada.

Nursing has become very fragmented over the years. We have our generalists and our specialists.

We have an increasing number of health care and health-related agencies which are employing nurses. Many nurses are in the educational field, preparing future nurses and assisting nurses to broaden their knowledge of nursing trends today and in the future.

In my opinion, there is a great need for a common, unifying bond for nurses in Canada. I see the Canadian Nurses Association as the vehicle that will do this. In unity there is strength. Strength is needed in nursing today to carry out the multiplicity of duties facing us now and to prepare us to meet the needs of Canadians with health-related concerns in the future.

We are fortunate to be living in a country with one of the best health care systems in the world. Nursing is a large part of our Canadian system. Each nurse in Canada should be prepared and willing to actively participate as a member of this system.



Kathleen McCutcheon, B.N. (McGill U.), Master's Candidate in Health Sciences (McMaster U.)

Present Position:

Clinical Coordinator, St. Paul's Hospital, Vancouver, B.C.

Association Activities:

RNABC — chairman of committee to approve continuing education programs (1974-75), member of nursing practice committee (1973-75) and registration committee (1972-74), board member (1971-73), member of task force committees that published two RNABC manuals.

I believe that the next few years will be turbulent times for those involved in the delivery of health care. Demands by the public for effective, humanistic services will increase.

Budgetary restraints will necessitate creative approaches in order to maintain an acceptable standard of health care. Nurses must have a major role in assessing, planning, implementing, and evaluating these changes.

If elected, I hope to both assist in the identification of positive contributions that nurses are and could be making to current and future health problems, and facilitate the sharing of this expertise at the national level.



Ginette Rodger, B.N. (U. of Ottawa), M.N.A. (U. of Montreal)

Present Position:

Director of Nursing, Notre Dame Hospital, Montreal, Quebec.

Association Activities:

President of the committee on the shortage of nursing personnel in Quebec (1975-76); CCHA — part-time nurse surveyor; member of the Hospital Association of Quebec, among others.

I have accepted nomination as member-at-large for nursing administration because I believe that, as director of nursing in a very active, 1,000-bed university hospital, I can make a valuable contribution to the board of directors. During my three years as director of nursing, I have lived a wide range of experiences. Facing up to the reality of the administrative field of the '70s and the '80s has been part of my everyday responsibility. Adapting to fast flowing change in a world of unrest, of professionalism, of politically-oriented unionism, of research, of teaching, while ensuring quality and quantity of care in spite of limited resources, is the nursing administrator's daily challenge.

Furthermore, I believe that being a member of the board of directors at the national level can be a rewarding professional experience, and can only prove to be positive as far as acquiring and sharing knowledge is concerned.

If you believe that I can adequately represent nursing

administration on the board of directors, I can assure you of my continued interest and availability.



Rusty (Sheila) Stewart, R.N. (U. of Alberta), Diploma in Teaching and Supervising Nursing (U. of Alberta) currently taking Hospital Organization and Management course (CHA)

Present Position:

Assistant Administrator of Nursing, Stanton Yellowknife Hospital, Yellowknife, N.W.T.

Association Activities:

NWTRNA - secretary (1976-77); editor of association newsletter; member of N.W.T. Hospital Association, International Association of Child Care Workers, and Canadian Association of Cardiovascular Nurses.

I believe that nursing administrators must be recognized as vital members of the administrative team. It is their responsibility, as leaders of the largest health professional group, to provide an environment in which nurses can learn and develop. New concepts in health care systems, moving from illness and cure orientation to health promotion, must be considered by nursing and utilized in future planning. The effective nurse administrator will assess, plan and implement new programs compatible with the lifestyles approach, and help individual nurses to develop attitudes conducive to high quality care. The establishment of standards of care and the formulation of methods to evaluate care is of prime importance to the nursing administrator today.

I feel that a representative from the Northwest Territories might lend a new and valuable viewpoint to the executive committee.

Candidates: Member-at-large, Nursing Education



Shirley Alcoe, B.A. (Acadia U.), R.N. (Metropolitan School of Nursing, Windsor), B.Ed. (U. of New Brunswick), M.A. (Columbia U.), M.Ed. (Columbia U.), Ed. D. (Columbia U.)

Present Position:

Associate Professor, Faculty of Nursing, University of New Brunswick, Fredericton, N.B.

Association Activities:

CNA — member of special committee on nursing research (1971-73); NBARN - member of ad hoc committee on role of primary care nurse (1973-74), chairperson (1976 -) and member since 1975 of scholarship committee; CNF — member of selection committee (1973-74); Canadian Lung Association - member of board of directors (1976-77), chairperson elect of nurses' section (1975-76), chairperson of health education committee (1976-77); president of Canadian Nurses' Respiratory Society (1976-77); member of board of directors N.B. section of the Canadian Cancer Society; has given numerous addresses and acted as resource person for a variety of professional groups.

It is my opinion that nursing education is now entering a period where necessity for the consolidation of past improvements and the introduction of innovations for future practice must be balanced wisely. This balancing act will become increasingly difficult as our society copes with the social unrest and economic troubles of our times.

Selected personal interests include:

- encouragement of dialogue on the educational process between faculty members and their students and on our society's expectations of nurses from consumers of health care and nurses in both education and service;
- development of accreditation program(s) for our schools;
- promotion of collegial relationships between employees of educational and service institutions;
- availability of continuing education programs relevant to every area of nursing;
- support for the development of teacher-preparation programs consistent with the anticipated levels of instruction (diploma, baccalaureate, graduate, continuing).
- ensurance of an equitable distribution of society's funds amongst all types of educational programs leading to health-care occupations.

Although these items represent some of my concerns, others will have equally vital interests. I believe the association has a duty to listen to its members, detect the educational issues, clarify the alternatives, select appropriate positions and direct its forces in a politically astute manner to enhance educational practices.

Because I have been either a student or teacher in every major type of educational program offered for nurses from a two-year diploma school to a graduate school, I can relate to all facets of nursing education with a personal understanding. I believe this background, combined with broad experience in the activities of nursing associations and voluntary and governmental health agencies, prepares me to serve you in the position to which I have been nominated. I have been schooled to be involved. I believe our mutual involvement can be rewarding.



Norma J. Fulton, B.Sc.N. (U. of Saskatchewan, Saskatoon), M.C.Ed. (U. of Saskatchewan)

Present Position:

Associate Professor and Director, Continuing Nursing Education, College of Nursing, University of Saskatchewan, Saskatoon, Saskatchewan

Association Activities:

CNA - member of ad hoc committee on continuing education in nursing (1973); SRNA - member of ad hoc committee on status of nursing (1977 - 78), member of coordinating committee on continuing nursing education (1971 -), member of task force committee on continuing education (1972-73); chairman of Canadian Council of Cardiovascular Nurses' committee on continuing education (1977 -); Saskatchewan Heart Foundation — member of board of directors (1974 -), vice-president (1976 -) and member since 1971 of professional education committee.

I am pleased to accept the nomination for the office of member-at-large representing nursing education for the Canadian Nurses Association.

I accept this nomination having taught in both diploma and baccalaureate programs and been responsible for developing a provincial continuing nursing education program. During the past six years, I have worked with many groups of nurses (cardiovascular, perinatal, operating room, occupational health, community health, directors of nursing, etc.) and have gained an appreciation of their needs in continuing education. I have had the rewarding experience of being able to plan, with their assistance, programs to meet those needs. This experience has also given me a

greater understanding of the current problems and concerns facing the diploma and baccalaureate programs.

I see nursing education as an ongoing process which begins in the basic program and continues throughout the nurse's professional career. The future will necessarily see a greater focus on continuing education, if standards are to be maintained, patient care improved, and opportunities provided for the individual's professional growth.

I would welcome the opportunity to serve as a member-at-large, nursing education.



Jane Haliburton B.N. (McGill U.), M.N. (Boston U.), Ed. D. (Boston U.)

Present Position:

Director of Education, Yarmouth Regional Health Complex, Yarmouth, Nova Scotia

Association Activities:

RNANS — chairman of resolutions committee (1977) among others, member of special committee on education (1977) and committee on research (1977) in addition to numerous others.

It is my belief that an individual has a responsibility to the group to which she belongs. I am a professional woman and a member of the Registered Nurses Association. Twenty years' experience in nursing service and education help provide background for a worthwhile contribution. Accepting a nomination at the national level is also a support of the provincial group.

Election to an office is the beginning of opportunity for personal growth, a chance to have new experiences and enlarge one's horizons. Meeting different people to exchange ideas, questions and philosophy can be a constructive way of sharing. Creative and innovative action often requires a period of quiet reflection, but it is in the stress of life that one gains material for reflection.



Margaret A. McCrady, B.N. (U. of Manitoba), M.Sc.N. (U. of Western Ontario)

Present Position:

Director of Educational Services, Nursing, Health Sciences Centre, Winnipeg, Manitoba

Association Activities:

CNA Testing Service — member of committee to prepare a blueprint for a comprehensive examination for nurse registration (1976); MARN — 2nd vice-president (1975-77), chairperson of committee to approve post-diploma programs (1977), member of ad hoc committee on conceptual models of nursing practice (1977), chairperson of nursing committee (1974-75).

I accept the nomination for member-at-large, nursing education. I believe that our national professional body, the Canadian Nurses Association, must provide leadership in addressing the many issues in nursing education — issues that transcend geographical areas and become concerns for all Canadian nurses.

I agree with the many nurses who believe that nursing must be responsive to the changing health and illness needs of society. Therefore I also believe that nursing education programs must be directed towards preparing skilled nurses for practice today and also for practice as it will be defined in the future.

I believe that to accomplish this, we must develop both sound basic education programs and realistic continuing education programs in nursing.

I also believe that both basic and continuing education programs must

be based upon valid standards and subjected to rigorous evaluation by consumers, nursing students, employers, and members of the society we serve.

If I am elected, I will be privileged to work towards the accomplishment not only of these objectives, but also of the broader goals that will be determined by the board of directors.



Margaret Neylan, B.N. (McGill U.), M.A. (U. of British Columbia)

Present Position:

Department Head, Psychiatric Nursing, British Columbia Institute of Technology, Burnaby, B.C.

Association Activities:

CNA — board of directors (1971-73); RNABC — president (1971-73), member of continuing nursing education group (1971-74), committee on nursing education (1974 and 76) and other sub-committees; member of provincial vocational, technical and other careers program consultative committee (1971-76); consultant on continuing nursing education to a variety of educational institutions and health care agencies in B.C. (1968-76); has published numerous articles and given many addresses to professional groups.

It is increasingly important that the Canadian Nurses Association play a coordinative planning role in matters affecting the practice and education of its members. If elected, I will endeavor to ensure that CNA seek information and advice from the provincial associations on educational issues. To assure effective care to patients, nurses must have access to a continuum of educational opportunities at diploma degree and continuing levels.

Previous experience as president of the RNABC, and as member of the CNA Board, will assist

me in contributing effectively as the member-at-large for nursing education.

My experience in nursing education followed an active career in nursing practice. My responsibilities in education have ranged from teacher to planner and administrator in a hospital school, an institute of technology, a university, and a provincial planning facility.



Amy M. Zelmer, B.Sc.N. (U. of Western Ontario), M.P.H. (U. of Michigan), Ph.D. (Michigan State U.)

Present Position:

Dean, Faculty of Nursing, U. of Alberta, Edmonton

Association Activities:

Canadian Health Education Specialists Society — chairman of committee on research and technical publications (1967 - 72), vice-president (1971 - 72) past editor of Film Index; CPHA — member of research and development committee (1973-74), past chairman of the health education section; author of numerous articles and papers on health education.

I believe that the current high-priority needs in nursing education are: — linking the different levels of practice and preparation so that individuals can rationally decide on a career pattern and employers can appropriately place practitioners; — developing means to ensure continuing competency of nurses in the face of a rapidly changing technology and the career patterns common to a profession largely composed of women; — establishing and maintaining standards of nursing care and education while giving increased attention to consumer (patient) rights, student rights, and the concern over increasing costs of health care and education. We must simultaneously become more humane and more efficient.

The CNA (and more particularly the member-at-large for nursing

education) has the opportunity and responsibility to:

- promote sharing of information and ideas on these and other issues within the membership so that alternatives may be thoughtfully considered;
- interpret the needs and the strengths of nursing education to the allied health fields and those concerned with education across the country;
- support the activities of provincial associations (and through them local groups) who will be able to take action on specific issues;
- act as a "distant early warning system" to alert practitioners and educators to new issues or trends which are arising (e.g., changes in the health care delivery system, financing, international requirements).

I am fortunate to be associated with an institution and a faculty that believe these concerns are important, and would, therefore, make it possible for me to devote the necessary time and energy to the position of Member-at-Large for Nursing Education.

These are exciting times for nursing and I would consider it a privilege to hold such a position.

**Candidates:
Member-at-large,
Nursing Practice**



Betty Lethbridge, B.N. (McGill U.), M.N. (Dalhousie U.)

Present Position:

Assistant Director, Victoria General Hospital, Halifax, Nova Scotia

Association Activities:

RNANS — resource person for the approval committee to review submission "patient care planning/quality assurance/nursing audit" (1977); chairperson of the quality assurance program, Victoria General Hospital (1976 -).

In this present day consumer-oriented society, nursing practice is being subjected to very close scrutiny.

Nursing as a profession has the responsibility and accountability for setting standards of nursing care and then practicing them. Standards of care will be set, and if nursing does not take the leadership in this, another group will.

The ever-increasing budget restraints are posing severe problems in our nursing practice. In the process of meeting the challenge of these restraints we must be a part of the focus finally shifting from illness to health-oriented care.



Karen M. Mills, B.Sc.N. (U. of Alberta), currently studying towards Master's in health services administration at U. of Alberta

Present Position:

Graduate student in health services administration at U. of Alberta. Associate Director of Nursing, City of Edmonton Health Department (on sabbatical leave until Sept. 1978).

Association Activities:

AARN — representative to universities coordinating council committee on nursing education (1973-77); CPHA — council member-at-large (1976-77), vice-chairman of the health promotion division (1975-), member of the editorial board for Canadian Journal of Public Health (1975-); Alberta Association of Public Health — chairman of health promotion section (1975-76).

I believe that we in the nursing profession have a profound potential for affecting the lives of those for whom we care. Not only in the sense of performing activities that current technology has made available to us, but in the unique opportunities we have to influence society's well-being. We are a large work force, and operate in diverse spheres, each of us with a particular focus of concern and contact, but in the end, seeking a common goal — the restoration, maintenance and promotion of the public's health.

From my perspective, we have only begun to explore and experience our potential to affect the health care system.

We need to learn to use ourselves more expertly, individually and collectively, as spokesmen for the consumer. Of equal importance, we need to learn to work with one another more effectively. Increased sharing and solving of nursing problems, improved communication and cooperation between all areas of nursing practice would benefit not only the consumer, but also our own development. In my view, the CNA Nursing Practice Standards Project is an important vehicle for effecting change.

As the member-at-large, I would work toward identifying and developing those strategies which would help the profession to increase its influence on the nation's health and on the way in which health care is delivered.

I consider this nomination to be a privilege, and if elected, will do my utmost to meet the expectations which the position places upon me.



Thérèse Schnurr, B.Sc.N. (U. of Seattle), M.N. (U. of Washington)

Present Position:

Director of the Nursing Division, Royal Columbian Hospital, New Westminster, B.C.

Association Activities:

CNA — member of ad hoc steering committee on development of a definition of nursing practice and development of standards for nursing practice (1975), member of resolutions committee (1970); has participated in writing guidelines for nursing on behalf of RNABC.

I accept the nomination as member-at-large for nursing practice.

Fundamentally, the future of the profession depends on working nurses — on the value they place on

their roles and on the decisive action they take to ensure the meaningful development of nursing.

One instrument for such action is the board of directors of the Canadian Nurses Association. It must actively employ every means in its power to assist nurses in determining the future of the profession in this country.

I believe my background and experience equip me to make a valuable contribution to achieving that end. If elected, it will be my privilege and an honor to serve the national membership by working diligently to enhance nursing practice in Canada.

Candidates: Member-at-large, Nursing Research



Janet Kerr, B.Sc.N. (U. of Toronto), M.Sc. (U. of Wisconsin), Doctoral Candidate In Education (U. of Michigan)

Present Position:

Associate Professor, Faculty of Nursing, University of Calgary, Calgary, Alberta

Association Activities:

AARN — chairman (1976-) and member of research committee, past member of task force committee to identify future role of the nurse; CNA Testing Service — past member of blueprint committee for surgical nursing; CAUSN — member of committee on studies (1977-) and ad hoc committee on funding for accreditation (1976) for the national division, and secretary-treasurer (1976-78) and member-at-large (1972-74) for the western region; has published books and articles and given numerous addresses on legal issues and gerontology to professional groups.

Advancement in the nursing profession must go hand-in-hand with clinical nursing research. As Robert K. Merton noted over twenty

years ago: "We must recognize that a profession is committed to the task of enlarging the body of knowledge that it applies to the problems and troubles with which it deals. A profession not rooted in systematic knowledge is a self-contradiction, a myth rather than a reality."

A growing number of nurses in Canada are becoming involved in developing and carrying out research projects. Research in the practice of nursing needs both educators and practitioners to identify significant problems and to do the research. The development of a climate for the promotion of nursing research requires the formulation of research policy at both the institutional and association levels.

In my experience as research committee chairman of the provincial professional association, it has become evident that there is a need for vision and courage to face the issues and make the decisions that will strengthen the rational foundations of our practice-based profession. As CNA member-at-large for research I would encourage and promote sound research policy development at the national level.



Odile Larose, B.N. (U. of Montreal), M.Nurs. (U. of Montreal)

Present Position:

Director of Nursing Section, Order of Nurses of Québec, Montreal, Québec

Association Activities:

Author of numerous articles in nursing and hospital administration publications.

I have accepted nomination as member-at-large for nursing research because I believe that nursing has its own core of knowledge and that CNA

is one of the best means to promote nursing research in Canada.

It is important that the nursing profession in Canada, through CNA, take a firm, enlightened and well-documented stand on nursing issues and health-related matters in general. The national association must take responsibility for analyzing all studies and documents in the health field, and specifically those which can affect the autonomy of the profession, the quality and availability of nursing manpower and the types of educational programs in relation to the needs of the population.

CNA must not only react to stands taken by other groups; it must become a forerunner in planning the future of nursing education and practice along the lines of our society's evolution. The Association must also help to steer the direction of federal government health programs while retaining the dimensions of the nursing care programs.

Nursing research is an essential means to this end. It must be used as a basis of all position statements. I believe nursing research is essential to the growth of the profession; it must not only be carried on in universities but also in the clinical setting and in nursing associations.

As director of the nursing division at the Order of Nurses of Québec, I am responsible for directing many research projects dealing with the practice of nursing, nursing functions, nursing care programs and nursing care per se. The experience I have acquired in planning the future of nursing and taking stands on all matters related to nursing at the provincial level, has prepared me to make a contribution at the national level.

I believe my experience as a practitioner, a nursing administrator and a resource person in nursing research can help me to assist CNA in developing nursing research in this country.

I believe that the national association must work more actively to promote nursing research, to define future avenues for nursing and to make available a doctoral program in nursing in Canada. The Association must also lead the way in analyzing nursing manpower, setting manpower standards in relation to Canada's health policies, and preparing this manpower.

As a member of the research committee for more than three years, I have gained valuable experience which will enable me to carry on the work started and bring the individuals involved in decision-making to consider the multiple components and implications of nursing research.

I believe that the future of nursing is in the hands of nurses and that research is an essential element in the growth of the profession.



Ruth C. MacKay, B.A. (McMaster U.), M.N. (Emory U., Georgia), M.A. (Emory U.), Ph. D. (U. of Kentucky)

Present Position:

Associate Professor, Dalhousie University, Halifax, Nova Scotia

Association Activities:

Active member of CNA, CNF and CAUSN, among others; author of numerous articles in professional journals.

During the last few years nursing research in Canada has grown to be of central concern to the profession. Increasing numbers of nurses have become involved in examining problems of nursing practice, the management of the care of patients and the education of nurses. Not only has attention been given to the investigation of nursing problems with a view to finding better ways of giving care to patients, but, in general, research has contributed to the development of nursing's body of knowledge.

Nurses now are demanding the right to examine their own practice to assert themselves to direct their own investigations. No longer are nurses content to gather data for others to evaluate and interpret, nor to be subjects in studies without involvement in the decisions needed to ensure quality service without exploitation of staff or patients. This kind of involvement requires nurses who are aware.

We as nurses need to identify problems in nursing which require study. We need the ability to examine published research findings to make wise decisions about what modifications are needed in our practice. We need the ability to assess the merits or proposed research before giving consent to researchers to engage in

investigations on subjects coming within our areas of responsibility. We need to collaborate with other professions in the common concerns of patient care. And some of us need to be investigators in our own right. As a profession, we have much to do.

I believe we as nurses have the strength and determination to work toward these goals in the further development of research in nursing in Canada. It is to this end that I have agreed to be nominated for the position of member-at-large for nursing research.



Annette Stark, B.S.N. (U. of British Columbia), M.P.H. (U. of Pittsburgh), Ph.D. (U. of North Carolina)

Present Position:

Associate Director, Division of Health Services Research and Development, University of British Columbia, Vancouver, B.C.

Association Activities:

RNABC — member of committee investigating mandatory registration for nurses (1971); member of Society for Epidemiological Research and CPHA among others; recipient of National Health Research Scholar Award (1977-).

Nursing research should be integrated into the broader study area generally called health services research. Here, the emphasis is on assessing how consumers benefit from health services and the investigation of what services best meet identified needs.

Nursing is a prominent (and expensive) component of both preventive and treatment programs.

Nurse researchers and their colleagues must identify problem areas and contribute their knowledge of nursing on interdisciplinary teams which study the provision of all health services. They must see that nursing issues — in fact, patient care issues — are studied in a way that helps practicing nurses meet the health care needs of consumers.

Candidates: Member-at-large, Social and Economic Welfare



E. Margaret (Peg) Bentley, R.N. (Royal Victoria Hospital), P.H.N. diploma (Dalhousie U.)

Present Position:

Consultant, Personnel Services, Registered Nurses Association of Nova Scotia, Halifax

Association Activities:

RNANS — consultant to social and economic welfare committee (1968 -) currently secretary and member since 1975 of the Department of Health/RNANS Liaison Committee; past president and vice-president of Public Health Association of N.S.; member of scientific planning committee for conjoint national and world federation public health conference (1978); currently vice-president of Institute of Association Executives.

For nearly ten years I have been working for the social and economic welfare of the nurses in Nova Scotia. During the first seven of those years I was directly involved with the organization for collective bargaining and the negotiating of the early contracts. Collective bargaining has helped many nurses to improve their working conditions and salaries; however, many are still not covered by collective agreements. I believe that there is a lot of work to be done for those who are not under contract.

The manner in which discipline is handled in the employment field, for example, is a matter of grave concern. I hope that continued work in this area will enlighten management, and improve working conditions and employment relations, in particular, for all concerned.

Continuing education is of great significance to all of us involved in the various fields of nursing. It is possible that the lack of proper preparation for many of the jobs, particularly in the management areas, has been the cause of some of the employment problems that nurses have been experiencing. I believe that continuing education programs should be available and that opportunities should be provided for nurses to take advantage of them.

Hospitals are now beginning to realize the importance of occupational health; there are as many hazards in connection with the hospital environment as with any other. As many as two hundred new hazards exist each year that were not known to exist the year before. Our continued promotion of occupational health can bring our concerns to the attention of more of our agencies throughout Canada.

Nurses need to be aware of the dynamics of politics in order to more properly present their views to government and to the community at large. There has been much more emphasis on health and welfare in the past few years and we as nurses need to be knowledgeable in order to help both ourselves and others. The work forces and the places of work are diversified. I believe that many nurses accept jobs without realizing the full import of the legal responsibilities they are assuming.

My personal hope is that I will be able, in some way, to assist the nurses in Canada with this dimension of their professional development and I would so direct my energies.



Linda Roberta Gosselin, R.N. (Toronto Western Hospital), B.Sc.N. (U. of Toronto)

Present Position:

Employment Relations Officer, Ontario Nurses' Association, Thunder Bay, Ont.

Association Activities:

CNA — Member-at-large for social and economic welfare (1976-78); RNAO — chairman (1974-76) and past member (1972-74) of provincial committee on social and economic welfare, member of executive committee (1974-76) and board of directors (1973-76); formerly president, chairman, secretary and nurse representative of negotiating committee for the Nurses' Association of the Lakehead Regional School of Nursing.

In these days of the budget versus quality care, it is most important that the professional association remain a viable and often-heard voice of nursing and nurses. It is inevitable that union groups whose memberships are mainly composed of registered nurses will become involved in nursing issues, but this should only enhance the advancement of nursing. The professional associations must promote cooperation and collaboration with these groups in order to further the best interests of nursing care.

Bargaining agents are not the only groups talking on behalf of nurses. Employers' associations are getting better daily in their attempts to tell the profession what is good for the patient and how nurses should provide it. Nurses are members of both these groups, and it is unfortunate that their comments and concerns about nursing are being

channeled through these bodies rather than through the professional association.

When choosing the primary route for nursing concerns to follow, the decision should automatically be in favor of the professional association. This puts the onus on the professional association to make certain the decision is a foregone conclusion. I firmly believe that it is the duty of the association to provide the channels to deal speedily and efficiently with members' expressed concerns.

It is not enough to say to membership — you are the association, you say what you want. Certainly membership has a responsibility to make known its problems and to offer its talents and ideas for finding solutions. But the association has the duty to promote listening within the profession, and to provide leadership in problem-solving.

Those nurses elected to leadership positions within the association have the responsibility to lead. We as members have the obligation to keep them informed. Together we have an association providing informed leadership and setting nursing trends.

I accept the nomination as member-at-large for social and economic welfare.

In my position as nurse administrator, I am most aware that the present economic situation in Canada has a related effect on our health care system. It is important for us to maintain the gains we have achieved in social and economic welfare; however, we must endeavor to retain the balance between our goals as practitioners and the social and economic welfare of our profession.

It is essential that other health care professionals and the general public recognize the role that we, as nurses, fill in the health care of the population. To enable us to be responsible, accountable and contributing members to the health care system, we must set our standards for practice and ensure that they are upheld. We can achieve this by continuing to work toward becoming a cohesive, recognized and decisive group of professionals. I believe a concerted effort at the national level is essential to meet this challenge effectively.



**Sister Barbara Muldoon, B.Sc.N.
(St. Francis Xavier U.), M.S.
(Boston U.)**

Present Position:

Director of Nursing Education, St. Martha's Hospital School of Nursing, Antigonish, Nova Scotia.

Association Activities:

RNANS — president and CNA board member (1974-76), past chairman of nursing education. ⚡

Candidates: Committee on Nominations



Marie Anne Toupin, B.N. (McGill U.), M.S. (U. of Colorado)

Present Position:

Assistant Administrator, Burnaby General Hospital, Burnaby, B.C.

Association Activities:

RNABC — member of project planning committee on new graduates and employment (1977), member of task force committee to review position paper on roles and functions of registered nurses; AARN — member of governing board (1974) member of ad hoc committee to assess genetic counseling needs for Alberta (1974); past council representative of Associate Members United Nurses of Montreal.



**Laura Butler, B.Sc.N.
(Lakehead U.)**

Present Position:

Director of Nursing, Thunder Bay District Health Unit, Thunder Bay, Ontario

Association Activities:

RNAO — president and CNA board member (1969 - 71); College of Nurses of Ontario — elected council member (1973-79).



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SUNDAY, JUNE 25

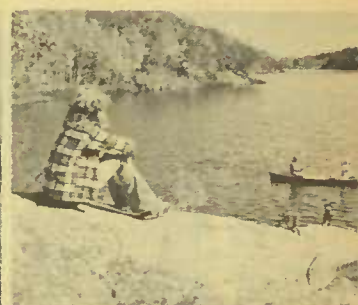
12:00	Registration <i>Convention floor</i>	
14:30	Canadian Nurses Foundation Annual meeting <i>Ontario room</i>	Margaret McLean , chairman
	Musical welcome	Bobby Gimby and children's chorus
19:00	Opening ceremony <i>Canadian room</i>	Joan Gilchrist , chairman
	Address "A challenge to the profession: the future"	Two cultural viewpoints, students of nursing
	Greetings	Representatives, Government of Ontario, City of Toronto Representatives: WHO, ICN, ANA.
	Welcome	Irmajean Bajnok , president, Registered Nurses Association of Ontario.
	Address "The emerging conflict of professional and consumer rights"	Bernadette Walsh , consumer advocate
20:30	Reception <i>Concert hall</i>	Host: Registered Nurses Association of Ontario

Place: Royal York Hotel, Toronto
Date: June 25-28, 1978
Theme: Ethical issues in nursing

MONDAY, JUNE 26

07:00	Candidates' canteen <i>Ontario room</i>	Host: Registered Nurses Association of Ontario
08:00	Registration <i>Convention floor</i>	
09:00	General session <i>Canadian room</i>	Joan Gilchrist , chairman
	Report of the Committee on Nominations	Huguette Labelle , chairman
	Nominations from the floor	Voting delegates
	Report of RNAO arrangements committee	Nancy Blackburn , chairman
09:45	Program <i>Canadian room</i>	Alice Baumgart , chairman, dean, school of nursing, Queen's University
	Address "The everyday realities of ethical concerns"	Dr. David Roy , director, Centre for Bioethics, Clinical Research Institute of Montreal
11:00	Break	
11:30	Address "Ethical issues in professional development"	Dr. Abbyann Lynch , department of philosophy, St. Michael's College, University of Toronto
	Discussion	Dr. Margaret Scott Wright , director, school of nursing, Dalhousie University Margaret Neylan , department head, Psychiatric Nursing, British Columbia Institute of Technology.
12:30	Lunch	
14:30	Program <i>Canadian room</i>	Sheila O'Neill , chairman, second vice-president, CNA
	Roundtable discussion "Ethics of nursing research"	Host: Laurier LaPierre , professor and historian, CBC radio and TV personality Participants: Dr. Moyra Allen , professor and director of research, school of nursing, McGill University; Huguette Labelle , director general, Policy, Research and Evaluation Branch, Department of Indian and Northern Affairs; Marie-France Thibault , associate professor, school of nursing, University of Montreal; Beverlee Cox , dean, faculty of nursing, University of Western Ontario
16:00	Exercise break	
16:05	Program	Rachel Bureau , chairman, education consultant, Société du Timbre de Noël du Québec Inc.
	Address "The professional association meets the challenge"	Marguerite Schumacher , dean, faculty of nursing, University of Calgary; Sheila Belton , former president, Saskatchewan Registered Nurses Association

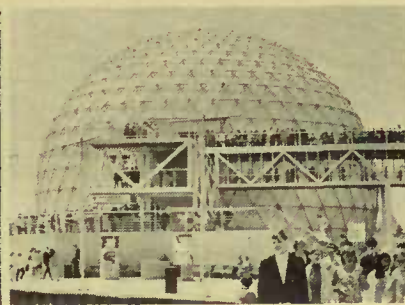
Welcome to Toronto: harbour boat tour,
Metro Caravan, sightseeing, etc. as arranged by RNAO



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TUESDAY, JUNE 27

08:00	Registration <i>Convention floor</i>	
09:00	General session <i>Canadian room</i> Appointment of scrutineers Appointment of Resolutions Committee Roll call President's address Report of the executive director	Joan Gilchrist, chairman Dr. Helen K. Mussalem
11:00	Break	
11:30	Open forum	
12:00	Lunch	
12:00-14:00	Election of officers <i>Territories room</i>	
14:00	Report of Committee on Testing Service Report of Special Committee on Nursing Research Auditor's report Appointment of Auditor Financial statement Changes in by-laws Invitation to 1980 annual meeting	Jean Dalziel, chairman Dr. Helen Glass, chairman Sue Rothwell, president, Registered Nurses Association of British Columbia
16:00	Exercise break	
16:05	Open forum	
16:30	Report of the scrutineers	
20:00	Public lecture "The frontiers of science and humanity"	Roy Bonisteel, TV personality and host of "Man Alive"



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WEDNESDAY, JUNE 28

08:00	Registration <i>Convention floor</i>	
09:00	General session <i>Canadian room</i> Report of the Resolutions Committee	Joan Gilchrist, chairman
11:00	Break	
11:30	Address "Canada Health Survey"	Elizabeth Stucker, nurse coordinator, Canada Health Survey, Health and Welfare, Canada
12:30	Lunch	
14:30	Program <i>Canadian room</i> Address "Current conflict and a look toward the future"	Joan Gilchrist, chairman Dr. M. Josephine Flaherty, principal nursing officer, Health and Welfare Canada.
15:15	Other business Installation of officers President's remarks	Helen Taylor, president-elect.
16:30	President's reception <i>Concert hall</i>	

Exhibits open daily from 08:30 to 18:00 from
Monday, June 26 to Wednesday, June 28 at 15:00

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New Volume II! **CURRENT PERSPECTIVES IN ONCOLOGIC NURSING.** Written by nurses for nurses, this innovative text focuses on the nursing process to help students become more aware of the intricate care required by cancer patients. Eighteen original articles explore professional awareness; therapy; maximizing the quality of life; and rehabilitation. Students will be especially interested in timely discussions of such often-neglected subjects as nutrition, the role of religion, and cancer of the aged. Edited by Carolyn Jo Kellogg, R.N., M.S.N., N.P. and Barbara Peterson Sullivan, R.N., M.S.N., N.P.; with 21 contributors. April, 1978. Approx. 208 pp., 26 illus. **About \$12.50(C), \$9.25(P).**

A New Book! **HYPERTENSION CONTROL FOR NURSES AND OTHER ALLIED HEALTH PROFESSIONALS.** How well do your students understand the problems faced by hypertensive patients? Reflecting a strong commitment to patient evaluation and teaching, this practical text exhaustively discusses the disease and its etiology, related complications, regulation/treatment, and counseling. A unique sample teaching booklet, and an extensive list of written and audio-visual resources are among other useful features. By Mahendra S. Kochar, M.D., M.S., M.R.C.P.(London), F.R.C.P.(Canada), F.A.C.P. and Linda M. Daniels, R.N., M.S.N.; with foreword by Harold D. Itskovitz, M.D., F.A.C.P. June, 1978. Approx. 240 pp., 17 illus. **About \$9.75.**

GERONTOLOGY

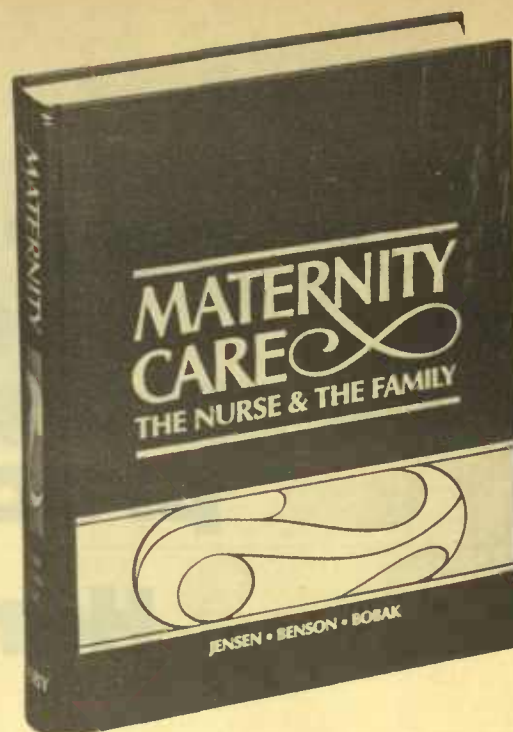
New 2nd Edition! **READINGS IN GERONTOLOGY.** Help your students work more effectively with their geriatric clients. This comprehensive text explores all aspects of aging — physical, psychological and social — and discusses the concepts and principles underlying a multidisciplinary approach. Students will benefit from timely new articles on human sexuality and the well elderly; aging blacks; intergenerational relationships; and developmental tasks. Edited by Mollie Brown, R.S.M., Ph.D.(candidate); with 12 contributors. March, 1978. 140 pp., 1 illus. **Price, \$7.75.**

PHARMACOLOGY

New 2nd Edition! **REVIEW OF PHARMACOLOGY IN NURSING.** Using a concise question/answer format, the new edition of this popular text emphasizes major drug categories . . . thoroughly examines basic pharmacologic actions . . . and provides a conceptual framework for further study. Important new features include a timely chapter on drugs affecting sexual response, the fetus and the nursing infant, along with comprehensive material on drug therapy in the elderly, CNS drugs, and psychotropic drugs. By Betty S. Bergersen, R.N., M.S., Ed.D. and Jurate A. Sakalys, M.S. May, 1978. Approx. 256 pp. **About \$9.75.**

MATERNITY CARE: The Nurse and the Family

By Margaret Duncan Jensen, R.N., M.S.; Ralph C. Benson, M.D.; and Irene M. Bobak, R.N., M.S.; with 2 contributors.



MATERNAL/CHILD

New 3rd Edition! **PEDIATRIC NURSING.** Turn to this exceptional text for a comprehensive overview of pediatric nursing. Stressing the promotion of children's health, it first explores growth and development, and explains variances in individual patterns. Subsequent chapters provide useful guidelines for effectively working with hospitalized children. Students will appreciate a timely new chapter on nutrition in pregnancy and lactation, and current information on genetic counseling, battered children, and psychological aspects. By Helen C. Latham, R.N., M.L., M.S.; Robert V. Heckel, B.S., M.S., Ph.D.; and Larry J. Hebert, B.S., M.D., F.A.A.P.; with 3 contributors. July, 1977. 622 pp., 253 illus. and 2 color plates. **Price, \$16.25.**



Photo courtesy David S. Strickler, Six Pix

New 3rd Edition! **MATERNITY NURSING.** Reflecting an increased emphasis on the *family* aspects of birth, this superbly illustrated text offers an excellent introduction to obstetrical and neonatal nursing. It describes both male and female reproductive anatomy . . . discusses pregnancy and growth/development of the fetus . . . examines labor and delivery . . . and explores the postpartum period *and* nursing care of the whole family. Students will especially appreciate valuable new information on fetal monitoring, family planning and congenital defects. By Constance Lerch, R.N., B.S.(Ed.) and V. Jane Bliss, R.N., B.S.N., M.S.N. January, 1978. 592 pp., 284 illus. with 1 color plate. **Price, \$16.25.**

New 4th Edition! **MATERNITY NURSING: A Self-Study Guide.** Useful as a companion to MATERNITY NURSING, or a review for important examinations, this practical workbook covers in-depth *all* phases of obstetrical and neonatal nursing. Students will answer thought-provoking questions on preparation for parenthood, diagnosis of pregnancy, fetal/maternal anatomy, normal and high-risk neonates and other key topics. Timely new material focuses on sexual self-image, maternal-infant bonding and parental grief patterns. By Constance Lerch, R.N., B.S.(Ed.) and V. Jane Bliss, R.N., B.S.N., M.S.N. January, 1978. 228 pp., 60 illus. **Price, \$7.75.**

"Birth is intensely personal, as well as universal. Each baby thrusts myriad alterations into an already changing world; each replicates and perpetuates humanity's countless generations." (From the Preface). Emphasizing the humanistic aspects of childbirth, this dynamic text prepares students to function more effectively as competent, sensitive maternity nurses. Chronologically organized chapters — highlighted by more than 650 outstanding illustrations — proceed from human sexuality to family planning, normal pregnancy and possible interferences, labor and its complications, the post partum period, and normal and high-risk newborns. Throughout, the authors integrate psychosocial aspects with clinical content — to help students fully understand and plan sound nursing care interventions. Definitive chapters on genetics, home delivery and legal aspects, an extensive glossary, and suggested readings following each chapter add to the comprehensiveness of this text.

1977. 784 pages. 684 illustrations. **Price, \$20.50.**

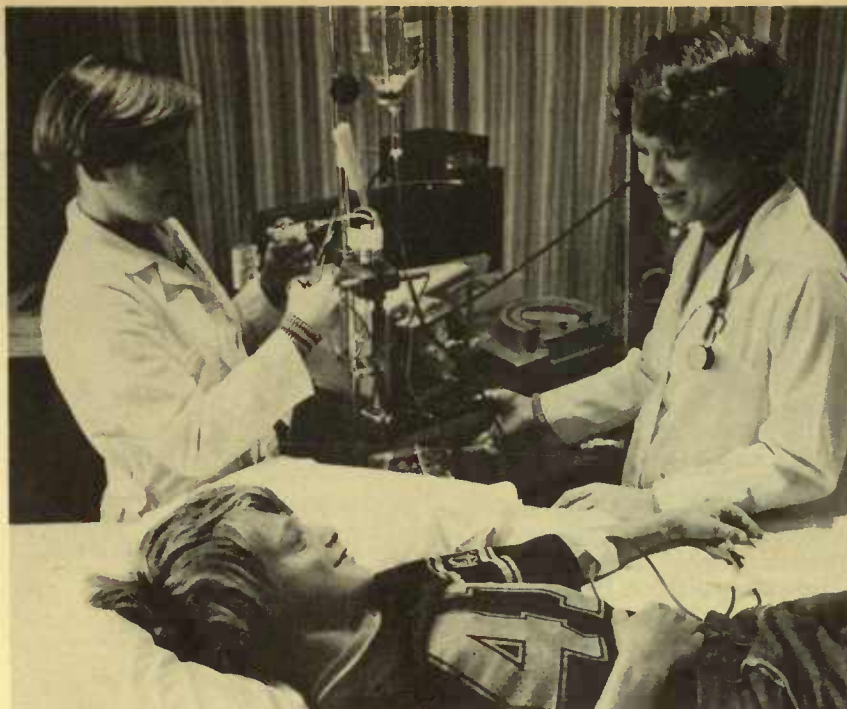
A New Book! **FETAL MONITORING AND FETAL ASSESSMENT IN HIGH RISK PREGNANCY.** Learning the intricacies of fetal monitoring can — at best — be extremely confusing. This unique text examines all methods — biophysical, electronic and biochemical — and discusses their use in detecting fetal difficulties and possible interventions. More than 100 superb illustrations and sample monitoring strips offer students valuable practice in identifying and interpreting fetal distress patterns. By Susan Martin Tucker, R.N., B.S.N.; with 1 contributor. June, 1978. Approx. 160 pp., 36 illus. **About \$9.75.**

New 3rd Edition! **BASIC PEDIATRIC NURSING.** Reorganized and updated, this introductory text offers LP/VN students a broad overview of their role in child care. Beginning chapters discuss growth and development of the healthy child; subsequent chapters focus on various childhood disorders and required nursing care. Student-oriented features include current information on neonatal care and diagnostic tests, and challenging study questions and summary outlines after each chapter. By Persis Mary Hamilton, R.N., P.H.N., B.S., M.S. February, 1978. 490 pp., 272 illus. **Price, \$10.75.**

A New Book! **FATHERING: Participation in Labor and Birth.** What do your students think about fathers in the delivery room? This humanistic text can help them develop an empathy with the father and better understand — and anticipate — his reactions. The authors first discuss the paternal role in labor and delivery and describe the physician's feelings. They then include actual interviews with fathers, offering students a fascinating look at a very important member of the birth team. By Celeste R. Phillips, R.N., M.S. and Joseph T. Anzalone, M.D. March, 1978. 164 pp., 73 illus. **Price, \$8.75.**

For more information on these and other Mosby texts, contact: The C. V. Mosby Company, Ltd., 86 Northline Road, Toronto, Ontario M4B 3E5. A80333

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PSYCHIATRY

New Volume II! **CURRENT PERSPECTIVES IN PSYCHIATRIC NURSING: Issues and Trends.** Written *by nurses for nurses*, this dynamic book offers students contemporary perspectives on therapies/strategies, dynamics and roles. Twenty original articles examine such important topics as sensory integration therapy, geropsychiatric nursing, photostudy as a diagnostic tool, sex role stereotyping, and much more. Throughout, diverse viewpoints give students a unique opportunity to take a creative look at psychiatric nursing. Edited by Carol Ren Kneisl, R.N., Ph.D. and Holly Skodol Wilson, R.N., Ph.D.; with 22 contributors. January, 1978. 228 pp., 2 illus. Price, \$12.50 (C), \$9.25 (P).

FUNDAMENTALS

New 2nd Edition! **KEY CONCEPTS FOR THE STUDY AND PRACTICE OF NURSING.** Extensively revised and expanded, the new edition of this widely adopted text helps students better understand themselves *and* their patients. The authors consider man as a set of human needs; discuss structural variables; and offer an effective framework for assessing patient needs. Students will benefit from timely new chapters on position and role and the nurse/client relationship. By Marjorie L. Byrne, B.S.N., M.S. and Lida F. Thompson, B.S.N., M.S. April, 1978. Approx. 160 pp., 17 illus. About \$6.50.

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Calendar

May

Post-diploma and upgrading courses offered at George Brown College in Toronto, Ontario:
Review of basics in nursing: Apr. 10-May 12, 1978
Long-term care and rehabilitation nursing: May 8-June 2
Medical-surgical module: May 15-July 7
Maternity nursing module: May 15-July 7
Pediatric nursing and psychiatric nursing: May 29-July 21
Critical care nursing: Aug. 8-Dec. 15
Child and family mental health: Aug. 14-Dec. 15
Neonatal intensive care nursing: Sept. 5-Dec. 15
Rehabilitation nursing part 1: Sept. 5-Dec. 15
Rehabilitation nursing part II: Jan. 16-Apr. 27, 1979.
 For more information concerning any of these courses contact: George Brown College, Nightingale Campus, P.O. Box 1015, Station B, Toronto, M5T 2T9.

Continuing Nursing Education given by the University of Alberta:
The high risk newborn: May 10-12, 1978. Fee: \$45.
Nursing management of the respiratory patient: May 12-13, 1978
E.C.G. interpretation: June 26-29, 1978. Fee: \$75.
The logic, strategies and tools for student clinical evaluation: Aug. 17-18, 1978.
 Contact: *The Faculty of Extension, The University of Alberta, 82 Avenue and 112 Street, Edmonton, Alta., T6G 2G4.*

Putting it together — the educational, medical and familial implications of learning disabilities. Hosted by the Calgary Association for Children with Learning Disabilities. To be held on May 4-6, 1978 at the Calgary Inn, Calgary, Alta. Contact: *Calgary Association for Children with Learning Disabilities, Room 2023, Mount Royal College, 4825 Richard Rd., Calgary, Alta., T3E 6K6.*

Hemodynamic Monitoring in the Critically Ill Patient to be held on May 5-6, 1978 at Mount Sinai Hospital, Toronto. Sponsor: Ontario Heart Foundation, University of Toronto, and the Royal College of Physicians and Surgeons. Fee: \$75. Contact: *Hemodynamic Monitoring Conference, 310 Davenport Rd., Toronto, Ontario, M5R 3K2. (416)-962-3600.*

National Hemophilia Conference to be held on May 19-20, 1978 at the Holiday Inn, Winnipeg, Manitoba. Contact: *Joan Reherie, 29 Cascade Bay, Winnipeg, Man.*

June

Call for papers for the 4th Annual Health Administration Forum to be held at the University of Ottawa campus on June 19-20, 1978. Any topic related to health administration is acceptable. If you have a topic to share, contact: *Gerald C. Hunt, Coordinator, Continuing Education Program, School of Health Administration, University of Ottawa, 545 King Edward Ave., Ottawa, Ont., K1N 6N5.*

Canadian Association of Neurological and Neurosurgical Nurses Annual Meeting to be held on June 21-23, 1978 at the Hotel Sheraton Landmark in Vancouver, B.C. Contact: *Pauline Weldon, Secretary, CANN, 25 Lawson Ave., Dartmouth, Nova Scotia, B2W 2Z2.*

Annual Convention of the Operating Room Nurses of Alberta (ORNA), to be held on June 19-20, 1978 in Edmonton's Holiday Inn. Theme: Basic trends for operating room nurses. Contact: *Mrs. B. Vickers, 100722-67th Ave., Edmonton, Alta., T6H 1Z9.*

Canadian Hospital Association Convention to be held in Calgary, Alta., on June 7-9, 1978. Guest speakers include Peter Lougheed, premier of Alberta and Claude Castonguay, who will speak on the Quebec Model. Fee: \$105. Contact: *Canadian Hospital Association, 410 Laurier St. West, Suite 800, Ottawa, Ontario.*

80th Annual Meeting of the Victorian Order of Nurses for Canada to be held on June 1-2, 1978 in Thunder Bay, Ontario. Contact: *Victorian Order of Nurses for Canada, 5 Blackburn Ave., Ottawa, Ontario, K1N 8A2.*

Three-Week Institute on Gerontology to be held at Boston University's Gerontology Center and Summer Term beginning June 12, 1978. Many aspects of the aging process will be covered by gerontology specialists. Contact: *Boston University Summer Term, 704 Commonwealth Ave., Boston, Mass., 02215.*

National Conference of the Canadian College of Health Service Executives, to be held on June 5-6, 1978 in Calgary, Alta. Theme: The call for leadership: expanding responsibilities. Contact: *David Sneddon, Director of Services, Canadian College of Health Service Executives, 410 Laurier Ave. West, Suite 805, Ottawa, Ontario, K1R 7T3.*

13th Annual Conference of the Association for the Care of Children in Hospitals to be held at the Washington Hilton, Washington, D.C. on June 5-8, 1978. Nearly 2,000 physicians, nurses, child life workers and others who work with hospitalized children are expected to attend the four-day conference. Among the many speakers are: Senator Edward Kennedy who will discuss "Legislating Health Care" and Richard Goldbloom, M.D., Physician-in-Chief, Izaak Walton Killam Hospital for Children in Halifax, Nova Scotia who will speak on "Alternatives to Traditional Pediatric Care." Other topics to be discussed include: play programs, death and dying, child abuse and protection, education of multi-handicapped infants etc. Fee: Members of ACCH \$45.; Non-members: \$65.; Students: \$35. Contact: *1978 ACCH Conference Office, Children's Hospital National Medical Center, 111 Michigan Ave., N.W., Washington, D.C. 20010.*

August

Seventh Conference and Exposition of the Canadian Medical and Biological Engineering Society. To be held at the Four Seasons Hotel, Vancouver, B.C., August 13-16, 1978. Seminars for nurses and other hospital personnel on: selection, use, care and control of medical devices, equipment-related hazards etc. Contact: *Conference Secretariat, Dr. James R. Heyworth, St. Paul's Hospital, 1081 Burrard St., Vancouver, B.C. V6Z 1Y6.*

October

10th Association of Operating Room Nurses International Symposium. A two-week symposium to be held on Oct. 14-29, 1978 in Manila, Philippines in conjunction with the World Conference of Operating Room Nurses. Theme: Together we can make it happen. Contact: *Association of Operating Room Nurses, 10170 E. Mississippi Ave., Denver, Colorado 80231.*

Did you know

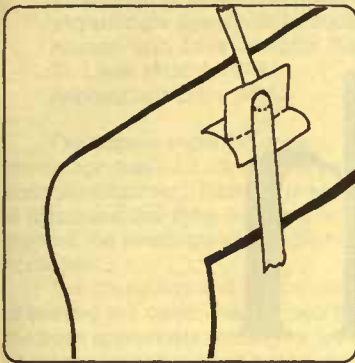
Grant MacEwan Community College began a two-trimester **Extended Care Nursing Program** in September of 1977. The course is designed to provide registered nurses with the opportunity to gain knowledge, skills and attitudes which will enhance their job satisfaction and performance in extended care settings. For information, contact: *Head, Extended Care Nursing Program, Grant MacEwan Community College, Box 1796, Edmonton, Alberta, T5J 2P2.*

Did you know ... The Alumnae of Sydney City Hospital, Sydney, N.S. will host a "Grand Reunion" for all graduates July 6th to 9th inclusive, 1978. Graduates who are interested and have not received a registration letter, contact the following address before June 1st, 1978: *Reunion Committee, Sydney City Hospital Alumnae, c/o Urquhart Hall Sydney, Nova Scotia, B1P 2H8.*

Here's How



Prevent Catheter Pull



In our intensive care unit, we have found an effective way to prevent catheter pull in male patients. Tape a wide elastoplast bandage on the patient's thigh, forming a deep ridge in the middle. Then cut a hole in the ridge just large enough to allow the drainage tubing to go through (the tubing should fit fairly snugly). The tubing should protrude about 1/2" through the hole where it is attached to the catheter. We have found this to be a big improvement over other methods of catheter taping or pinning.

— *Katy King, staff nurse, cardiac surgery unit, Ottawa Civic Hospital, Ottawa, Ontario.*

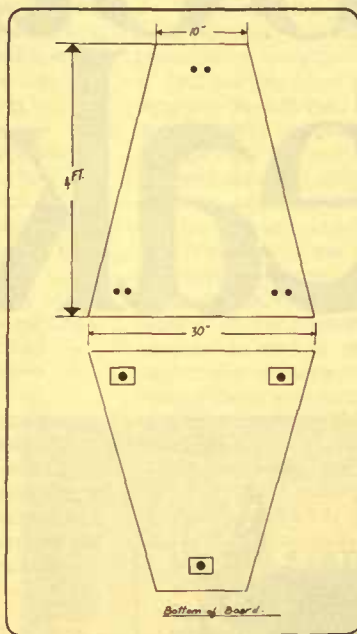
Infant Water Bed

In a neonatal intensive care unit where I used to work, the nurses used an inexpensive and efficient way to prevent skin breakdown in babies. The nurses there used plastic IV bags (full of solution) to accomplish a ripple mattress effect in the following way: they just lined up the bags of intravenous fluid side by side to form a mattress, then covered them with a sheet. This created the same beneficial effects to the infant's skin as a ripple mattress or water bed.

— *Gail Gleason, staff nurse, coronary care unit, Ottawa Civic Hospital, Ottawa, Ontario.*

Skate Boards and Hip Spicas

At Children's Hospital of Eastern Ontario, we use skate boards to allow a degree of independence to children otherwise immobilized by hip spica casts. The plywood board can be made easily and cheaply by volunteers. Three six-inch blocks are mounted to the bottom of the 5/8" board and casters are applied to the blocks to allow mobility. The child can propel himself on the board by using his arms to push and steer.



Volunteers and Plywood

Skateboards aren't the only thing that volunteers can put together to make life a little easier for patients at Children's Hospital of Eastern Ontario. A child with only one hand prompted the invention of a card holder that would allow him to play cards in spite of his handicap.

Wheel-chair trays are also easy to make. We use a tray with a ledge around the sides and front — tailor made to fit around the child in the wheelchair. The size used depends on the size of the patient. It can be used to hold meals, craft materials etc.

— *Children's Hospital of Eastern Ontario, Ottawa, Ontario.*

ICU Tips

In our cardiac care unit, we have found that adding 1/2" of savlon and water to gastric suction or other suction bottles before using them, is a big help. We have found that it not only cuts down on the bacteria count in the drainage but also makes the bottles easier to clean.

We have also found that a surgeon's glove half filled with water and tied tightly with an elastic, serves as an effective cushion for heels or elbows that are breaking down.

— *Patricia Sullivan, staff nurse, cardiac surgery unit, Ottawa Civic Hospital, Ottawa, Ontario.*

Every nurse has practical ideas gathered from his or her experience on how to make life a little easier for nurses and for patients. *Here's How* is a column for you and your ideas. If you have an original and practical suggestion that you think might help other nurses to improve any aspect of patient care, why not share it with other nurses? We'll send you \$10. for any suggestion published. Let's hear from you. Write: The Canadian Nurse, 50 The Driveway, Ottawa, Ontario, K2P 1E2.

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Books

Endocrine problems in nursing: a physiologic approach by Judith Amerkan Krueger and Janis Compton Ray. 165 pages. St. Louis Mosby, 1976.
Approximate price \$6.60

The authors wrote this book to "provide a physiologic basis for care of the patient with an endocrine disorder." Each of the seven basic glands is discussed and there is a chapter devoted to the thymus, the pineal gland and gastrointestinal hormones.

The physiology and pathophysiology are presented in a basic, easy to read manner, making the book appropriate reading for a student learning about endocrinology or for a graduate working in the area. The authors emphasize that this is only a beginning, suggesting that further reading is necessary.

Each chapter is concerned with a specific gland. After a discussion of the anatomy and physiology of the gland, related diagnostic procedures and pharmacologic preparations are reviewed. Nursing care involved with a disorder of the gland is discussed according to a patient-problem/nursing-implication format. This provides the reader with a review of the nursing responsibilities based on the medical model. Several interesting illustrations are included throughout the book.

The main thrust of the book is to provide up-to-date information in the complex area of endocrinology. It is essential that the nurse have sufficient knowledge of the physiology/pathology of the condition to make a meaningful assessment of a patient's problems. From this point, the nurse can make informed decisions in the planning and implementation of her care.

Reviewed by Susan M. Fred, School of Nursing, Health Sciences Centre, Winnipeg, Manitoba.

Maternal-infant bonding: the impact of early separation or loss on family development by Marshall H. Klaus and John H. Kennell. 257 pages. Toronto, Mosby 1976.
Approximate price \$9.40 (hardcover)
\$6.60 (paperback)

Maternal-Infant Bonding deals exclusively with the very unique and complicated process "... of the earliest relationship that a baby develops with his parents ...". The authors approach this topic with sensitivity and understanding of the real problems and issues surrounding it. They correctly and realistically present many of the problems and current practice in institutions carrying out obstetrical care which tend to dehumanize this relationship.

Some of the ways in which the authors

present their material make the book extremely interesting and exciting. These include:

- Patient interviews which make what the authors are trying to tell us come alive. These give you insight into parents' feelings, concerns, hopes regarding their newborn babies and their individual problems.
- Comments by various authorities in certain subject areas are scattered throughout the book. These comments do not necessarily agree or disagree with the authors; however, they do make you think about the material presented and sometimes put a new slant on it.
- Many different and unique experiments are included which have been carried out, or are in progress, on the topic, as well as being related to it. The authors have presented many of these experiments with their findings, which substantiate their material. These experiments deal with animal relationships, as well as human maternal and paternal behavior. Interestingly, many behaviors exhibited within animal species on the subject are very similar to human behavior.

The book is well organized and includes an extensive reference list, index and many interesting pictures. It encompasses the bonding process of the normal newborn baby with his parents, as well as extensive material on the relationship of parents with a premature or sick infant, infants with congenital malformations plus a chapter concerning the care of parents when an infant dies.

I, personally, feel that health personnel

working in obstetrical areas and especially in high-risk nurseries, would gain much practical knowledge from reading this book. Nurses, especially see the initial interactions between the newborn baby and his mother. Valuable clues are given as to various interpretations of these interactions and possible approaches which could help foster a much more therapeutic relationship.

Reviewed by Judy Grant, nursing instructor, School of Nursing, Sydney City Hospital, Sydney, N.S.

Reading EKGs correctly by Margaret Van Meter and Peter G. Lavine. Jenkintown, Pa., Intermed Communications, Inc., 1977.

Many books have been written and are in use at the present time on the subject of E.K.G.s and their interpretation for nurses. Most have one problem — they are either very complex or too simple.

This book attempts to overcome both extremes by looking at the most basic E.K.G.s all the way through to the most complex E.K.G.s and their nursing implications. Included is a chapter on monitors and "troubleshooting" which is invaluable because it stresses the patient rather than a machine.

The authors' main objective is to encourage the reader to use a problem-solving approach, and in my opinion the book certainly meets this objective.

The book is a programmed text with many examples and exercises with E.K.G. strips as well as programmed learning with cardiac drugs. The appendix brings all of the chapters together with their special significance.

A significant statement which is often repeated is that the interpretation of more complex arrhythmias is open to debate, and that the reader should learn to review the steps taken to arrive at the interpretation, therefore teaching the concept of exploring every possibility.

The book would be of value to:

- student nurses in diploma programs — as an introduction to E.K.G.s;
- registered nurses in general — to improve their skills in interpretation;
- C.C.U. nurses, as a review and a stimulus to further knowledge.

Obviously I found this book valuable and would consider it for post-diploma courses in coronary care nursing. It has certainly stimulated me to review my own knowledge of E.K.G.s.

Reviewed by David M. Parry, coordinator, Diploma Nursing; administrator, Continuing Education Programs for Nurses, St. Clair College of Applied Arts and Technology, Windsor, Ontario.

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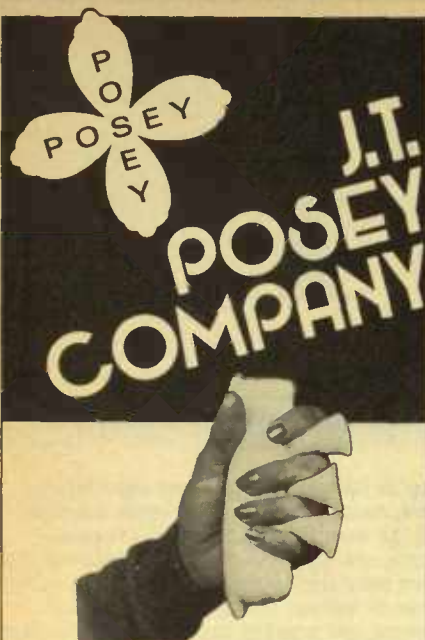
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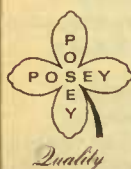
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Library Update

Publications recently received in the Canadian Nurses Association Library are available on loan — with the exception of items marked **R** — to CNA members, schools of nursing, and other institutions. Items marked **R** include reference and archive material that does not go out on loan. Theses, also **R**, are on Reserve and go out on Interlibrary Loan only.

Requests for loans, maximum 3 at a time, should be made on a standard Interlibrary Loan form or by letter giving author, title and item number in this list.

Books and documents

1. Addison-Wesley's nursing examination review. Sally L. Lagerquist, editor. Menlo Park, Ca., Addison-Wesley Publishing Co. Health Sciences Division, c1977. 454p.
2. *Agency for International Development*. International directory of women's development organizations. Washington, D.C., 1977. 311p. **R**
3. *Allenspach, Heinz*. Flexible working hours. Geneva, International Labour Office, 1975. 64p.
4. *The American Cancer Society's National Conference on Human Values & Cancer, Atlanta, Ga., June 22-24, 1972*. Proceedings. New York, American Cancer Society, 1973. 185p.
5. *American Nurses' Association*. Congress for Nursing Practice. A plan for implementation of the standards of nursing practice. Kansas City, Mo., c1975. 47p.
6. *Birchenall, Joan*. Soins aux personnes âgées, par ... et Mary Eileen Straight. Montréal, Renouveau Pédagogique, c1977. 238p.
7. *Brown, Byron Wm*. Statistics; a biomedical introduction. New York, Wiley, c1977. 456p. (Wiley series in probability and mathematical statistics).
8. *Caire, Guy*. Freedom of association and economic development. Geneva, International Labour Office, 1977. 159p.
9. *Carpentier, J*. Night work; its effects on the health and welfare of the worker, by... and P. Cazamian. Geneva, International Labour Office, 1977. 82p.
10. *Chisholm, Barbara A*. The child as citizen; a series of three monographs concerning children's rights. Ottawa, Canadian Council on Children and Youth, 1977. 3v.
11. *Clark, Carolyn Chambers*. The nurse as group leader. New York, Springer, c1977. 179p.
12. Conciliation in industrial disputes; a practical guide. Geneva, International Labour Office, 1973. 133p.
13. *Corporation professionnelle des médecins du Québec/Professional Corporation of Physicians of Quebec*. Rapport, 1976/77 Montréal, Corporation professionnelle des médecins du Québec, 1977. 64p.
14. Cultural dimensions in the baccalaureate nursing curriculum. New York, National League for Nursing, c1977. 114p. (NLN Pub. no. 15-1662).
15. *Davidson, Sharon Van Sell*. Nursing care evaluation; concurrent and retrospective review criteria. Saint Louis, Mosby, 1977. 420p.
16. *Doughty, Dorothy Beckley*. Nursing audit, by... and Norma Justus Mash. Philadelphia, Davis, c1977. 225p.
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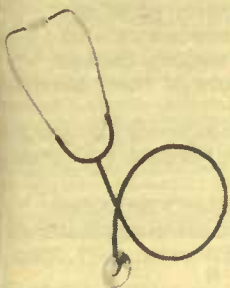
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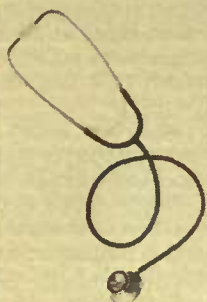
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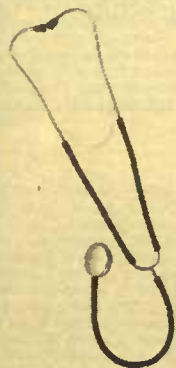
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Registered Nurse in the province of New Brunswick, or eligible for same, with practical experience in hospital work preferred.

Bachelor of Education Degree or Baccalaureate Degree in Nursing.

Salary:

\$1089 — \$1219 per month (Credit allowed for previous experience.)

Job Duties:

To plan or implement workshops, courses, and programs related to staff orientation and education under the direction of the Director of Staff Education.

Please apply in writing with a complete resume to:

Personnel Office
Saint John General Hospital P.O. Box 2100
Saint John, New Brunswick E2L 4L2

Vancouver General Hospital

requires

REGISTERED NURSES

Applications are invited from nurses interested in permanent or temporary employment with British Columbia's major teaching and referral hospital. Vacancies exist in both medical and surgical units as well as several specialty areas.

If you are interested in immediate or future vacancies or would just like to know more about nursing opportunities at Vancouver General Hospital, write to us. Please include information regarding your nursing experience and the areas and level of position in which you are interested.

Our present salary range at the General Duty level is \$1,184 to \$1,399 per month (1977), and an excellent benefit package is offered.

Contact:

Mrs. J. MacPhail
Employee Relations
VANCOUVER GENERAL HOSPITAL
855 West 12th Avenue
Vancouver, B.C. V5Z 1M9

Judy Hill Memorial Scholarships

Applications are being received for two annual Scholarships details of which are as follows:

Value: Up to \$3,500.00 each.

Purpose: To fund post-graduate nursing training (with special emphasis on midwifery and nurse practitioner training) for a period of up to one year commencing July 1st, 1978.

Tenable: In Canada, the United Kingdom, Australia & New Zealand.

Applicants should possess the following qualifications:

- Fluency in English;
- * R.N. Diploma, or equivalent;
- A desire to work for the Government of Canada or one of its Provinces at a fly-in nursing station in a remote area of Northern Canada for a minimum period of one year following completion of the scholarship year (Details of this work will be forwarded on request).

And should submit:

- A resume of academic and nursing career to date, together with a brief statement of the applicant's outside interests;
- Copies of the educational qualifications submitted on entry to nursing school;
- Verification of R.N. Diploma, or equivalent;
- Verification of Citizenship;
- The proposed course of study;
- Acceptances and/or preferences for place of study;
- Two character reference letters. One of these to be from a Health Service Professional familiar with the Applicant's nursing experience. In reaching their decision, the Trustees attach considerable importance to the advice of the referees.

To: Philip G.C. Ketchum,
Chairman, The Board of Trustees,
Judy Hill Memorial Fund,
15325 Whitemud Road
Edmonton, Alberta, T6H 4N5

By: May 31st, 1978

The Scholarship is contingent on the successful applicant being registrable by a nursing association in one of the Canadian provinces and being a Canadian citizen or able to meet current Canadian requirements for employment with the Public Service of Canada.

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For further information on any, or all, of these career opportunities, please contact the Medical Services office nearest you or write to:

Medical Services Branch
Department of National Health and Welfare
Ottawa, Ontario K1A 0L3

Name

Address

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Contact our:

Director of Nurses
McKinley General Hospital
1901 Red Rock Drive
Gallup, New Mexico 87301
U. S. A.

Call Collect: (505) 863-6832.

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The University of British Columbia Health Sciences Centre Psychiatric Unit Division of Nursing

Head Nurse — (Senior Care Co-ordinator)

The Health Sciences Centre Psychiatric Unit, The University of British Columbia is accepting applications for the position of Head Nurse on a 22-bed active treatment psychiatric unit organized around the primary nursing concept. Salary and benefits in accordance with the R.N.A.B.C.

Qualifications

- Baccalaureate or higher degree in nursing.
- Minimum of two years psychiatric nursing experience, preferably in a psychiatric teaching and research setting or other relevant nursing experience in mental health.
- Proven managerial competence and leadership skills.
- Registration (or eligibility for) with The Registered Nurses Association of British Columbia.

Written application accompanied by a resume of qualifications and names of two referees should be submitted to:

Co-ordinator of Hospital Employment
Employee Relations
University of British Columbia
Vancouver, B.C. V6T 1W5

The University of British Columbia Health Services Centre Psychiatric Unit

requires

Registered Nurses

Positions are available for Registered Nurses to function as members of interdisciplinary teams to provide assessment and care to patients in a 60 bed psychiatric unit. The unit comprises three wards and is located on the University of British Columbia campus.

Personal resumes should be submitted to:

Hospital Employment Division
Employee Relations
University of British Columbia
2075 Wesbrook Crescent
Vancouver, B.C.
V6T 1W5

Positions are open to both female and male applicants.



**Don't be afraid of me
even if you are not a
psychiatric nurse
(You can learn
to be one!)**

If you are interested in finding out about a speciality that is different, challenging and very worthwhile, you may be the person we are looking for and you are invited to join a 9 month *POST-GRADUATE* course in Psychiatric Nursing.

Our programme is designed especially for R.N.'s, whether you desire a stepping stone or further expertise in Mental Health.

The course includes theory and clinical experience in hospital and community settings with stress in the primary therapist concept, successful completion leads to eligibility for licensure with the R.P.N.A.M.

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For further information please write no later than June 15, 1978 to:

Director of Nursing Education
School of Nursing
Brandon Mental Health Centre
BRANDON, Manitoba.
R7A 5Z5



General Duty Nurses

The Royal Alexandra Hospital, 970 Bed teaching hospital requires:

General Duty R.N.'s

for temporary vacation relief positions in most clinical areas. Positions vary in duration between 9 weeks and 20 weeks, depending on clinical area. Employment date — July 4th, 1978.

Applicants must be eligible for Alberta registration with A.A.R.N.

Please direct inquiries to:

Mrs. R. Tercler
Director of Nursing Personnel —
Administration
Royal Alexandra Hospital
10240 — Kingsway Ave.
Edmonton, Alberta
T5H 3V9

Staff Nurses Operating Room

We require staff nurses to work in the Operating Room of Calgary's largest general hospital. Applicants must be eligible for registration in Alberta and have experience or advanced preparation in this specialty area.

The salary range is \$1059 — \$1265 per month (1978 rates under review) plus education and shift premiums. There is a comprehensive benefit package including denture.

Please apply to:

Personnel Department
Calgary General Hospital
841 Centre Avenue East
Calgary, Alberta
T2E 0A1

Guelph General Hospital Requires the Services of a Head Nurse for Emergency Department

Preferably applicants should have working experience in Emergency plus some administrative experience; a post-graduate course in Administration would be an asset.

Our 250-bed fully accredited hospital is located in a university town in south west Ontario.

Competitive salary and insurance benefits are available.

Resume of training and experience should be submitted to:

Personnel Officer
Guelph General Hospital
115 Delhi Street
Guelph, Ontario
N1E 4J4

ASSISTANT DIRECTOR OF NURSING

This 1260 bed teaching hospital involved in a major building project requires an Assistant Director of Nursing. This newly created position will report directly to the Vice President Nursing. The incumbent will be primarily responsible for the overall administration of Nursing Services for Paediatrics, Neonatal ICU, Obstetrics, Psychiatry, Emergency and Extended Care.

REQUIREMENTS: Post Basic preparation required, preferably at the Masters' level. Experience in Nursing Administration at the Supervisory, Assistant Director or Director level is essential.

Please reply with a comprehensive resume to:

Vice President — Nursing
University of Alberta Hospital
112 Street — 84 Avenue
Edmonton, Alberta
T6G 2B7

HEAD, NURSING CONSULTANT SECTION

Alberta Hospital Services, Edmonton, requires a highly qualified individual with a basic degree and post graduate university training in a field related to this position plus extensive experience in nursing service administration and clinical nursing. Substantial formal training and experience in the reactivation and rehabilitation fields is also a requirement. Some previous involvement in the organization and delivery of patient care programs an asset.

Applicants should have a proven capacity to counsel and direct a group of professional consultants, provide consultative services to health institutions and possess an ability to evaluate individual situations in the context of the total health care system.

Salary \$17,880 — \$23,472

Competition No. M341-10

To remain open until a suitable candidate has been selected.

Apply to:

Alberta Government Employment Office
5th Floor, Melton Building
10310 Jasper Avenue
Edmonton, Alberta
T5J 2W4

Registered Nurses Excellent Opportunity in So. Calif.

Hemet Valley Hospital, a modern 182-bed acute care facility expanding to 252 beds, has immediate openings for Registered Nurses. Hemet is located in an inland valley at the base of the San Jacinto Mountains approximately 85 miles northeast of San Diego. Lakes, beaches, mountain resorts, golf, Palm Springs and other recreational-resort areas within one hour's driving time. RN's with a California license and recent hospital experience start at a salary exceeding \$1070 per month with annual step increases. Nurses not licensed in California start at a lesser salary until receipt of California license. Shift differential (Eves — \$60, Nights, — \$90) and a good benefit package also provided. If you would like to know more about this excellent opportunity, please contact:

Myron L. Grindheim
Personnel Director
Hemet Valley Hospital District
1116 E. Latham Avenue
Hemet, California 92343

Telephone: (714) 652-2811

Equal Opportunity Employer

Immediate openings now available for Registered Nurses in a growing 250 bed hospital located in Southeast Texas. This medical/surgical hospital is dedicated to providing total patient care through primary nursing to our patients. The hospital is located in Southeast Texas ninety minutes from Houston and thirty minutes from the Gulf Coast and Louisiana. In addition to excellent salary, our benefit package includes free retirement, partial payment of relocation expenses, payment of a differential to ICU/CCU, 3-11, and 11-7 RN's and LVN's, eight paid holidays, health insurance at a nominal cost, and other significant financial benefits as an employee. If you are interested in obtaining additional information, complete the coupon below and mail to Cindy Stinson, R.N., Beaumont Medical Surgical Hospital, P.O. Box 5817, Beaumont, Texas 77702, or call collect 713/833-1411.

Name: _____

Address: _____

INSTRUCTOR/CO-ORDINATOR STAFF EDUCATION- Operating Rooms

A vacancy will exist May, 1978 for the above position in the Operating Room of the VANCOUVER GENERAL HOSPITAL — an active teaching and tertiary referral hospital for the Province. The department consists of 30 theatres involved in all surgical disciplines. Duties will include planning, organizing, evaluating, directing and co-ordinating as well as orientation and staff development for all categories of personnel in the Operating Rooms.

The successful applicant will be a B.C. Registered Nurse, preferably with a B.S.N. degree and Post Graduate Course in Operating Room Techniques or equivalent. Previous teaching experience preferred. Salary and benefits according to the R.N.A.B.C. contract.

Please send resume to:

Mrs. J. MacPhail
Employee Relations
VANCOUVER GENERAL HOSPITAL
855 West 12th Avenue
Vancouver, B.C. V5Z 1M9

McMASTER UNIVERSITY EDUCATIONAL PROGRAM FOR NURSES IN PRIMARY CARE

McMaster University School of Nursing in conjunction with the School of Medicine, offers a program for registered nurses employed in primary care settings who are willing to assume a redefined role in the primary health care delivery team.

Requirements Current Canadian Registration. Sponsorship from a medical co-practitioner. At least one year of work experience, preferably in primary care.

For further information write to:

Mona Callin, Director
Educational Program for Nurses
in Primary Care
Faculty of Health Sciences
McMaster University
Hamilton, Ontario L8S 4J9

Management Position In Public Health Nursing North Eastern Alberta Health Unit

Progressive, expanding rural Health Unit requires a **Supervisor of Nurses** to participate in the overall management of the Health Unit as related to Public Health Nursing.

Minimum Requirements:

R.N., plus Baccalaureate in related field and experience in administration.

Apply to:

North Eastern Alberta Health Unit
Box 1468
St. Paul, Alberta
T0A 3A0

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DEPARTMENT OF
HEALTH AND SOCIAL DEVELOPMENT

The School of Psychiatric Nursing,
Selkirk Mental Health Centre
is offering a

Post — Basic Course in
PSYCHIATRIC NURSING for

Registered Nurses currently licensed in Manitoba or eligible to be so licensed. (Preferably with University credits in Introductory Psychology and Introductory Sociology)

The course is of nine months duration September through May and includes theory and clinical experience in hospitals and community agencies, as well as four weeks nursing of the mentally retarded.

Successful completion of the program leads to eligibility for licensure with the R.P.N.A.M.

For further information please write no later than June 16, 1978 to: Director of Nursing Education, School of Psychiatric Nursing, Box 9600, Selkirk, Manitoba R1A 2B5



The University of Alberta Faculty of Nursing

The University of Alberta Faculty of Nursing invites applications at the **Associate Professor level to fill a recently established Clinical Nurse Researcher position.**

Doctoral preparation with recent clinical and research experience (preferably with emphasis on acute care nursing) is required.

Responsibilities will include research program development with selected teaching and thesis advisement in the graduate program.

The University of Alberta offers equal opportunity for employment to qualified male and female applicants.

Position will remain open until filled.

Apply to:
Dean
Faculty of Nursing
University of Alberta
Edmonton, Alberta
T6G 2G3



The University of Alberta Faculty of Nursing

The University of Alberta Faculty of Nursing invites applications for a term or **regular appointment** to fill anticipated vacancies.

Master's degree with recent clinical experience in Med/Surg Mental Health, Pediatrics, or Community Health required.

Responsibilities include teaching in the undergraduate program (4 year basic and post-RN), implementing a revised curriculum and opportunities for research and community service.

Deadline for application — 15th May 1978.

Starting date — July 1978.

The University of Alberta offers equal opportunity for employment to qualified male and female applicants.

Please make further inquiries, or submit application and curriculum vitae to:

Amy E. Zelmer, Ph.D.
Dean
Faculty of Nursing
The University of Alberta
Edmonton, Alberta
T6G 2G3

Co-ordinator

Assume responsibilities regarding organization of a Nursing Assistant Course to the James Bay Area natives.

Requirements:

Experience in teaching (3 years minimum)
Experience in an isolated area
Bilingual (French-English)

Salary:

According to the Teachers' Collective Agreement, plus an isolation and availability premiums.

Send curriculum vitae to:

Projet: Cours Infirmière-Auxiliaire
a/s Louise Vidal
Hôpital Chashasipich
Fort-Georges, Baie James
Nouveau-Québec, J0M 1E0
Telephone: (819) 981-2844

Port Saunders
Community Health Centre
requires

Registered Nurses

Applicants must be registered or eligible for registration with the Association of Registered Nurses of Newfoundland.

Positions available May 1978.

Salary is on the scale \$9,963. - \$12,282

Living-in accommodation available for single applicants.

Applications should be addressed to:

Mrs. Madge Pike
Director of Nursing
Community Health Centre
Port Saunders, Newfoundland
A0K 4H0

Nurse IV (Nursing Supervisor — Nights)

Required for 340 bed Level IV extended care hospital.

Qualifications:

Must be eligible for R.N. or R.P.N. Saskatchewan registration.

Successful experience as Head Nurse or Nursing Supervisor desirable.

Knowledge of labour relations and relevant legislation.

Salary Range:

\$1171-\$1419 per month.
(Currently under review).

For further information, contact:

Mr. L.D. Kennedy
Director of Personnel
Souris Valley Extended Care Hospital
Box 2001
Weyburn, Saskatchewan
S4H 2L7

MINISTRY OF HEALTH
NURSE SUPERVISOR
AFTERNOONS

Competition No. 78: 633-38

At **RIVERVIEW HOSPITAL**, ESSONDALE to be responsible for directing/co-ordinating administrative and clinical nursing activities during the hours of 1600-0010.

Qualifications: Degree in Nursing, specializing in psychiatric/geriatric nursing; registered or able to obtain registration in R.N.A.B.C./R.P.N.A.B.C.; extensive related experience, including supervision.

Salary: \$19,188 - \$22,476

Obtain applications from and return immediately to Valleyview Lodge, Essondale, V0M 1J0.

SENIOR COMMUNITY NURSE

Competition No. 78: 537-38

At **TERRACE** to assist and substitute for, Public Health Nursing Supervisor in overall operation of service and carry administrative/supervisory responsibilities; to interpret public health services and provide some direct patient/family care if necessary.

Salary — \$1,502-\$1,769, plus northern allowance.

ASSISTANT HOME CARE
CO-ORDINATOR (half-time)

Competition No. 78: 538-38

At **PENTICTON**, to assist and substitute for Co-Ordinator in planning/administering Home Care Program; to assess eligibility of patients for home care, co-ordinate individual patient care plans, liaise with physicians, hospitals and community agencies; to maintain related records and statistics.

Salary — \$680.50-\$804.00.

COMMUNITY NURSE

Competition No. 78: 539-38

At **CAMPBELL RIVER** and **VARIOUS** other locations in the province, to provide general public health nursing service, counselling and crisis intervention service in the area concerned; to liaise with health professionals and others providing care, and encourage appropriate use of available facilities.

Salary — \$1,361-\$1,608.

Candidates for all positions require university degree in nursing, including public health training where applicable, or equivalent combination of education and experience; preferably some general nursing experience (three years' experience required for position at Terrace); registered or able to obtain registration in R.N.A.B.C.; use own car, or government car, on mileage basis.

Obtain applications from the **PUBLIC SERVICE COMMISSION**, 1190 Melville St., Vancouver V6E 3W1 OR, 544 Michigan St., V8V 1S3 and return to **VICTORIA** immediately.



Province of British Columbia
Public Service Commission

544 Michigan Street, Victoria, B.C. V8V 1S3

REHABILITATION CONSULTANT

Provision of guidance and leadership in the rehabilitative and reactivational content of patient care programs to maintain and upgrade standards as appropriate to various facilities under the jurisdiction of the Department to which the successful applicant will function as a resource. **Qualifications:** Graduation from an acceptable school of nursing plus B.Sc. Eligibility for registration with the A.A.R.N. and graduation from a recognized program in rehabilitation and reactivation. Considerable related experience.

Salary to \$19,620

Competition No. 9212-1

Will remain open until a suitable candidate has been selected.

Apply to:

Alberta Government Employment Office
5th Floor, Melton Building
10310 Jasper Avenue
Edmonton, Alberta
T5J 2W4

NURSES

Alberta Hospital Ponoka, 60 miles South of Edmonton, has positions available for General Duty and Psychiatric Nurses. This hospital, an active treatment psychiatric facility of the Alberta Social Services and Community Health Department, requires nursing staff to provide all aspects of professional nursing care on a rotating shift basis.

Qualifications: Graduation from an approved school of nursing. Must be eligible for registration with the respective professional Alberta Associations. Salary range from \$12,804 to \$15,060 per annum.

Competition No. 9184-3

To remain open until suitable candidates have been selected.

Apply to:

Personnel Director
Alberta Hospital Ponoka
Box 1000
Ponoka, Alberta
T0C 2H0

Associate Director of Nursing

Applications are invited for the position of Associate Director of Nursing in a 500 bed accredited general hospital.

The Position:

As a member of the Nursing Administration team, this position requires a nurse with innovative qualities and ability to organize, delegate, and direct the work of others.

The applicant must have an enthusiasm for initiating and following up new ideas, projects and programmes.

Minimum Qualifications:

Must be currently registered in the Province of Ontario. Preference will be given to candidates with a B.Sc.N. and experience in Hospital Administration.

Apply in writing to:

Director of Personnel
Belleville General Hospital
Belleville, Ontario
K8N 5A9

Required:

DIRECTOR OF PATIENT CARE for a progressive 130-bed hospital. The hospital offers a full range of acute facilities, intensive care, psychiatry and extended care. The geographical area offers a range of outdoors and indoors recreational facilities.

Duties:

The incumbent would be responsible for the management and operation of the Patient Care Department, in accordance with departmental and hospital objectives, policies and standards. Future hospital expansion would require participation in the expansion program.

Qualifications:

Preference to the applicant with advanced educational, clinical and management preparation, with a minimum of five years senior management experience, or its equivalent. Current B.C. registration.

Salary:

Negotiable, but dependent on qualifications and experience.

Interested applicants submit complete resume to:

Administrator
Cranbrook and District Hospital
Cranbrook, British Columbia
V1C 3H9

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The Canadian Nurse

May 1978

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Close to 40 countries will be represented at this month's International Congress of the World Federation of Public Health Associations in Halifax. Only a few of them have been successful in developing their health delivery network to achieve wide coverage of their population and, of these, most make extensive use of a primary health worker like the one on our cover, a "barefoot doctor" in the People's Republic of China. "Rain or Shine" by Liu Hsu-hsu is one of 77 Chinese peasant paintings currently touring Canada under the auspices of the National Gallery of Canada. *The Canadian Nurse* acknowledges the kind permission of the Government of the People's Republic of China and the National Gallery of Canada to reproduce this painting. Photo by Studio Impact, Ottawa.

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses Association.

ISSN 0008-4581

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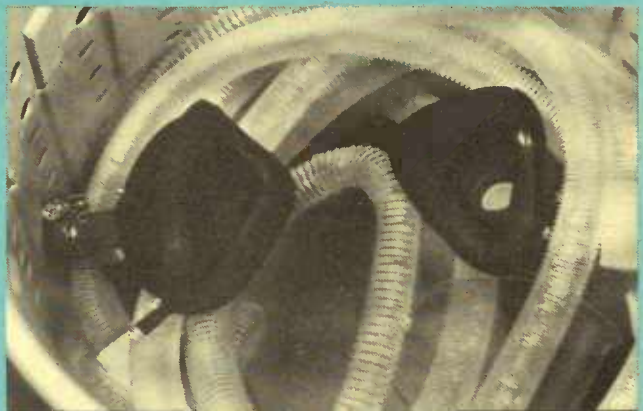
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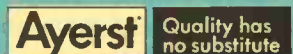
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Perspective

Rolling with the punches

One of the recommendations that came out of the first meeting of the editorial advisory panel set up last year to advise and assist the editors of *The Canadian Nurse* and *L'infirmière canadienne*, was the suggestion that the number of issues published annually be reduced from twelve to eleven. The committee saw the step, which was later approved by CNA's Board of Directors, as one way of offsetting the inflationary trend that has sent production costs for the two journals skywards in the past two years.

Postage and paper have been the two main culprits. On April 1st of this year, for example, postal rates for third class mail went up by 25 percent. This translates into mailing costs of \$200,000 annually, (up from \$162,000 in 1977) for twelve issues each of the two publications.

Paper costs, as any consumer knows, have also increased dramatically as the economy struggles with depletion of its scarce resources. Close to 20 tons of paper are used to print each month's issues of *The Canadian Nurse* and *L'infirmière canadienne*. Two years ago, a ton of paper cost \$2,120. Today it costs almost \$3,000.

And so it goes. Over the years, since it was established in 1905, *The Canadian Nurse* has changed as it has adapted to the circumstances that prevailed at any given time. As a fledgling publication, seventy some years ago, the journal was issued quarterly and available to subscribers at a cost of 50 cents per year. A total of 1000 copies of each of the first four issues were produced. At the end of World War II, *The Canadian Nurse* had a grand total of 4916 paid-up subscribers.

By 1958, the year that the national association celebrated its 50th anniversary, circulation had jumped to almost 40,000 readers and the journal was a hefty 104 pages.

Today, more than 97,000 copies of *The Canadian Nurse* and 43,000 copies of *L'infirmière canadienne* roll off the press each month.

Nine years ago the federal government acted to reclassify mailing privileges of professional journals like the two CNA publications. Loss of commercial second class privileges and reclassification into the much more expensive and less efficient third class category, was reflected in a smaller magazine (81 pages) produced on flimsier paper (to reduce weight). For the reader, it has also meant frustrating delays in receiving each month's issue. Even so, mailing costs went from \$9,000 in 1969 to \$108,000 in the following year — an unbelievable 1200 percent increase.

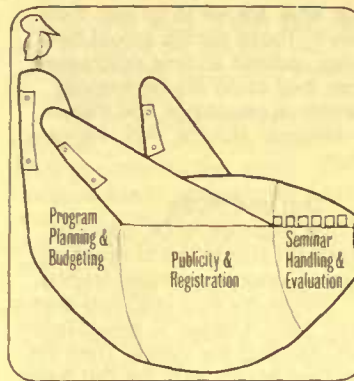
Changes like these have meant continual re-adjustment of our editorial sights. This year we're looking at eleven issues of *The Canadian Nurse* with 64 pages in each. But rolling with the punches has its advantages too. Bigger is not necessarily better. A more critical approach to content means a more readable product for the subscriber.

And, with all the changes, the original objective of stimulating and serving the profession that supports *The Canadian Nurse*, has remained essentially unchanged. Twenty years ago, Isobel MacLeod, chairman of the editorial board at the time, commented on the usefulness of the journal.

"Through it," she said: "we are developing the confidence to learn from unpleasant experience and to listen to our critics with understanding. We are looking at ourselves; we are permitting other people to look at us and we are looking beyond ourselves to see where we can make a greater contribution to Canadian society. Our Journal is helping us to keep in touch with ourselves and with society."

The essentials remain unchanged. This is YOUR journal. It exists through you and for you. With your continued support it will continue to serve you in whatever format circumstances dictate.

-M.A.H.



Herein

Have you ever wondered what goes into planning a nursing workshop, conference or seminar? Have you ever thought that you'd like to be involved? **Next month**, Leslie Joan Key and Marina Heidman, two nurses who have been involved in conference planning for a number of years, share their knowledge with you. They offer practical guidelines and suggest ways in which you can turn a good program idea into a reality.

For some patients, **cancer chemotherapy** means the start of a new life; for others, it means a series of painfully tolerated injections that carries with it a host of unpleasant and sometimes life-threatening side effects. This month, author Karla Rose explains how chemotherapeutic agents work and gives you some hints on how to help the patient who undergoes these treatments. The **Stress of Chemotherapy** begins on page 18 of this issue.

Watch for ... our special Summer edition of *The Canadian Nurse*.

The July/August issue of *The Canadian Nurse* will feature, besides the normal complement of articles, a special report to membership on the association's celebration of its 70th anniversary at the annual meeting and convention in Toronto on June 25 to 28.

A case of mistaken Identification ... As several of our readers have pointed out, nursing pin number eleven in the display featured in the March issue, was incorrectly identified as that of Victoria Public Hospital in Victoria, B.C. when it actually belongs to Victoria Public Hospital in Fredericton, N.B. Our apologies to VPH graduates.

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Dorothy Miller, *public relations officer, Registered Nurses Association of Nova Scotia.*

Jerry Miller, *director of communications services, Registered Nurses Association of British Columbia.*

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The Canadian Nurse invites your letters. All correspondence is subject to editing and must be signed, although the author's name may be withheld on request.

Input

Bravo to C. Sklar

Compliments to Corinne L. Sklar for her two articles in *The Canadian Nurse*, and *L'infirmière canadienne* March 1978... It is gratifying and very useful to have documentary material on legal matters which can be used as an authoritative guide. I hope the articles will continue.

—Francine B. Collin, inf., Rimouski, Québec

Sharing Information

I would like to express my appreciation for the article "Now you're on cortisone," by Bonnie Hartley (February).

Ten months ago my 16-year-old daughter had surgery at Montreal Neurological Hospital. Now she takes 25 mg of cortisone a.m. and 12 1/2 mg p.m. She found the article very clear and helpful.

I am passing it along to others.
—Helen Melanson, R.N., N.B.E.P.C. Occupational Health Nurse, Charlotte Co., N.B.

Growing old happily

I would like to comment on the recent closure of various nursing homes here in Winnipeg. I must say that I feel sad for the people who were removed from these homes.

I'm young, myself, but the thought of being taken to a new residence, without any say in the matter, seems slightly cruel. Many of these people had lived in these homes for many years, developing friends and becoming used to routines, etc. Now, they have been placed in new surroundings and probably parted from their friends.

We, as a society, are responsible for these people but we do not seem prepared to assume the consequences of their happiness/unhappiness. These people made this country "happen," and I don't believe that it's their idea that they be kept alive just to exist.

As nurses, we are taught to save lives and prolong them as long as possible. Why??

Between the lines, we hear "why are there so many elderly people dependent on these nursing homes

and what are we to do with them now?" These homes should have been updated as time progressed, then they could still be enjoying familiar surroundings and friends.
—Maureen Morrice, R.N., Winnipeg, Man.

Diet and PCBs

In response to Dr. Sabry's editorial I should like to relate my own experience in breast-feeding.

When my third child was born in July, 1976, I began to breast-feed her, as I had the others. Then the troubles began: from the first week, constipation; the second week, little red pimples all over her face; the third week, red oozing pimples especially on her face but also elsewhere, eyelids and ears swollen and discharging.

I went to my family doctor who exclaimed: "Your baby has a food allergy!" I was puzzled. Myriam's only food was my milk.

At the end of a week I weaned the baby. There were changes in a week and, after five weeks she seemed well, apart from a slight discharge from the ear. She had a clear skin and her bowel movements were becoming progressively more normal. I breathed again, but I didn't understand it.

In August 1976, *La Presse* published two articles on the contamination of milk by PCBs, a non-biodegradable substance used as insulation in refrigerators and discharged into waterways over the past 30 years. According to these articles, all the watercourses of North America would be contaminated by PCBs as well as by mercury, DDT and other pollutants. Analysis of the milk of 1,000 women showed that the milk of 80 of them was contaminated by PCBs. Poisoning symptoms in the babies, which were those of liver disorders and skin diseases, strongly resembled Myriam's. Unfortunately, this information appeared a month too late. My milk had never been analyzed.

Now I appeal to nurses in the maternity and public health fields when I say: "Mother's milk is good, but not always."

—Lutgart Hince, inf., Lorraine, Québec

Hobson's choice

Z.I. Sabry's guest editorial in *The Canadian Nurse* (February, 1978), "Mother's Milk: Is It Safe?" should be commended for calling attention to the environmental contamination dilemma. However, the author's recommendation that mothers switch to formula feeding leaves much to be desired.

Switching to cow's milk formula is no guarantee that health and contamination problems will be solved. Cow's milk allergy has long been associated with the increased incidence of upper respiratory infections, gastrointestinal upsets and eczema in formula-fed infants. In addition, the level of contamination in the formula itself varies according to the plant where it was manufactured.

It seems almost impossible to completely avoid exposure to DDT and PCBs in our environment. However, rather than switching the infant from nutritionally superior breast milk to cow's milk (and then possibly to soy-based formula), it seems far more sensible to encourage mothers to protect their families by taking the following actions:

Mothers should avoid food which may have been sprayed with pesticides; eliminate fresh water fish and animal fats on meat; stay away from crash diets which may release greater amounts of the PCBs stored in the mother's body fat into the breast milk; and support legislation aimed at protecting the environment.

Furthermore, before mothers have their milk analyzed, they should be informed that a baby is already exposed to possibly harmful substances while still in the womb. Mothers should also be advised that the level of DDT and PCBs in human milk varies on a day-to-day basis. A one-time analysis of milk should not be the criterion for making such an important decision.

To date, available data indicate that the small amounts of contaminants in breast milk have resulted in no demonstrable adverse effects in breastfeeding babies. The proven nutritional, immunological and psychological benefits of breastfeeding continue to outweigh the theoretical risks.

In fact, breast milk provides many functions which cannot be duplicated by any formula. For example, in the early stages of lactation, the IgA antibodies in the colostrum of human milk represent the mother's immunities over a substantial period of time. But the mammary gland also provides active ongoing protection during the entire course of lactation by producing increases in the IgA and IgM antibodies in response to local infection. (Whittlestone, W.G., D.S. "The Biological Specificity of Milk," *La Leche League International*, November 1976).

In light of the above information changing the environmental situation instead of recommending a switch from breast milk to formula should be the primary thrust of understanding concerned health care professionals.
—Dale G. Blumen, Professional Liaison Leader, *La Leche League International*, Newport, R.I.

Cause for Panic!

I have no praise to offer *The Canadian Nurse* and *L'infirmière canadienne* for their February 1977 editorial.

If mother's milk represents a danger for infants, I believe the problem must be tackled at its root by reeducating mothers about their diet and lifestyle. The quality of mother's milk will thus be improved and babies will not be deprived of what is in fact better for them.

Mothers already lack encouragement from their obstetricians and pediatricians and are very ambivalent about breast-feeding. Your editorial poses this question: "Should mothers breast-feed their babies? If not, what are the alternatives?" Now there is cause for panic! How many hospitals are prepared to do a satisfactory analysis of mother's milk? How can we stimulate the absorption of cow's milk in the newborn child?

We ought to inform and reassure the public, not alarm them and then supply a poorer solution!

—Christine Levesque, Sillery, Québec

Mother's milk: is it safe?

How heartbreaking that it should come to this! One of the most beautiful relationships is that of the breast-feeding couple: mother and baby. And now this may be threatened by the dangers of pesticides in our foods. Certainly very alarming!

There must be solutions other than switching to formula after a few weeks. Perhaps through stricter eating habits and greater awareness of the dangers involved, a woman could continue to nurse her baby and give him all the benefits of her milk and the warm, secure relationship this provides.

We are continuously exposed to environmental pollutants. It is a huge problem and as nurses we must get involved to try and stop the use of these chemicals.

But although a baby on formula may receive less of these pesticides than if he were drinking mother's milk, once he begins on other foods he will also quickly become "contaminated." It is generally true that babies on formula are given solid foods earlier than breast-fed babies, so this is only a short-term advantage compared to the many long-term advantages of breast-feeding.

I do not deny the dangers of these chemicals, but please, let us

look to other ways to limit their use and to reduce the amounts we consume before advocating a switch to bottled formula.

Too often over the last few decades, the swing has been towards bottle-feeding, often because health professionals have accepted it as an easy solution to a problem without looking for other alternatives.

Let's think twice this time and give our help and support to the breast-feeding mother who knows she is doing what is best for her baby.

— Jennifer Martin, R.N., Montreal, Quebec.

Did you know ...

Canada's only hospital north of the Arctic Circle, Inuvik General, has now received accreditation from the Canadian Council of Hospital Accreditation. The 55-bed hospital has a staff of five doctors and 46 nurses. These people, according to Dr. F.J. Covill, chief medical officer for the Northwest Territories, "deserve a great deal of credit for the first-class care they provide under isolated and sometimes difficult conditions."

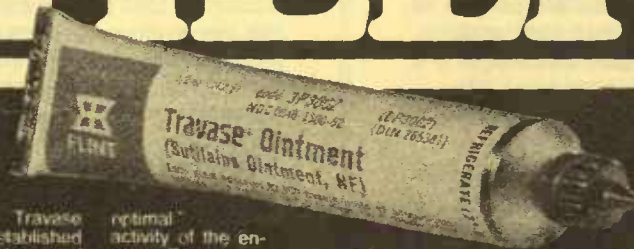
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YOU AND THE LAW



Unwarranted disclosure

Corinne Sklar

Are you a "gossipy nurse"? If so, you may be headed for trouble.

Sylvia and Jim*, both 19 years of age, were afraid that they had contracted VD. After considerable hesitation, they showed up at the emergency department of their local hospital where, they were relieved to learn, no one need know of their visit. Special arrangements were made for them to obtain the test results in person from the hospital so that they would not have to worry about awkward telephone calls at their homes. The test results were negative but the effect on their personal lives was not.

A nurse who worked at the hospital happened to be a friend of Jim's parents. She learned of their visit and told Jim's mother. The result: an angry confrontation, remonstrations, tears and pain for all concerned.

By the very nature of their work, nurses are privy to all sorts of personal, intimate information about their patients. The possibilities for "gossip" are infinite and disclosures like the one described above, however well-intentioned, are both ethically and legally wrong. That's why, almost as soon as they enter nursing, students are informed of their professional duty to maintain confidentiality regarding their patients and warned against frivolous discussions concerning patients.

Professional responsibility

The principle of confidentiality is rooted in two sources: professional ethics and the law. The Code of Ethics of the International Council of Nurses (adopted by the Canadian Nurses Association) states:

- The nurse shall maintain at all times the highest standards of nursing care and of professional conduct.
- Nurses hold in confidence all personal information entrusted to them.

* Based on an actual case, names changed to protect confidentiality.

Legislation regulating the practice of nursing in each province incorporates this ethic of confidentiality under the concept of professional misconduct for which a nurse may be disciplined (or even lose her registration depending on the severity of the offence). The offence may be expressed as "divulging a professional secret"¹ or as "failure to exercise discretion in respect of disclosure of confidential information about a patient".² However it is described, it is a basic tenet of nursing practice to maintain confidentiality regarding the patient, his condition, or any personal information learned about him during the course of his treatment.

Legal responsibility

The nurse's duty to maintain confidentiality arises out of the nurse-patient relationship itself: the free flow of communication between patient and nurse is a necessary element in patient care. The more a patient communicates with and to staff, the better his needs may be met, thereby facilitating total patient care. The nurse/patient relationship, like the physician/patient relationship, is one in which the patient's expectation is that confidentiality will be maintained. It is a relationship of trust. When the physician, hospital or nurse agree to care for the patient, it is implicit in the undertaking that confidentiality will be maintained. The patient has the legal right to have such expectations met.

Another legal footing on which the right to confidence is based, is the right to privacy. At common law there is no separate wrong (tort) protecting this right. In the United States, the right to privacy is constitutionally protected by the Fourteenth Amendment. In Canada, two provinces have enacted legislation creating, by statute, protection of privacy rights.³

Our right of privacy refers to the right to be "left alone", to "sheltering one's private life from the degrading effect of intrusion or exposure to public view".⁴ However, the common law does not specifically protect this broad right. Rather it protects specific personal interests from unwarranted intrusions.

- For example, the right of the individual to dwell on his land free from intrusion is protected by the civil wrong of trespass and the law of nuisance.
- Personal integrity of one's person is protected from physical harm by affording redress for assault and battery.⁵
- The tort of false imprisonment protects against unwarranted restraint of movement and, in this way, reinforces assault and battery in protecting the privacy of one's body.
- The law of defamation protects the person's good name and reputation, thereby safeguarding the individual's dignity, his sense of honor and self-respect.

This same law of defamation may apply when a nurse breaches the patient's right of privacy with unwarranted comments about him.

Sources of information

Nurses have access to much information of a highly personal and intimate nature regarding the persons entrusted to and trusting in their care.

They obtain this information from a number of sources. The primary source is usually the patient himself, through direct communication with him or his family. Nursing observations of the patient yield additional information (of which the patient himself may not be aware). Oral communication with the physician and other members of the health team provides further data. Finally, the chart itself is a basic source of information regarding the patient.

Professionally, ethically and legally, it is the nurse's responsibility to hold all this information in confidence.

However, effective communication is an essential element of nursing practice. The free flow of information between nurses and the members of the health team is necessary to the patient's care and treatment. The nurse must disclose her knowledge of the patient so that optimum care can be delivered to him. Disclosure of necessary and appropriate information to those directly involved in the care and treatment of the patient is not the issue here. It is the unwarranted, gossipy, or maligning type of communication that nurses must avoid: the "shop talk" on the bus or subway, at a party, in a cafeteria or in the hospital corridors and elevators.

Disclosure valid

The legal duty not to disclose such information arises out of the confidential relationship of nurse and patient. However, this duty is not absolute. Nurses may be required to disclose patient information in the following situations:

- **Statutory Requirement:** Some statutes require reporting of information by the recipient, e.g. Child Welfare Acts. (A statute is an Act passed by the provincial or federal legislature and is the law in that area.)
- **Public Policy:** Reporting to parents regarding a health problem of their young child.
- **Patient Consents.**
- **Required by the Court.**

Court ordered disclosure

Communications which are protected from disclosure even in a court of law are called privileged communications. The solicitor/client privilege is the one most commonly known. Such a communication is protected at common law and is the only professional relationship whose communications are so protected. In Canada, communications — that is statements made patient to physician, penitent to priest, are not privileged so that a physician or priest could be compelled to testify in the courtroom as to what he had been told. Customarily however, courts will try to avoid ordering the violation of such confidences

(continued on page 8) ▶

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Quebec is the only province in which there is a legal privilege between penitent and priest, physician and patient (also dentist and patient). This privilege is given by statute. In some American states, the nurse/patient relationship gives rise to the privilege. In Canada, the nurse/patient relationship is *not* privileged so that if called to give testimony the nurse may be compelled to disclose confidential information. Once the judge orders her to testify, the nurse must give the information, saying no more than is necessary to answer the question. It is possible that the custom of not compelling medical testimony might be extended to the nurse/patient relationship but this would depend on the issues and material facts of the case.

Defamation

Nurses should be aware that derogatory statements made about patients (or other staff members!) may give rise to a legal suit in defamation. Defamation refers to statements which harm the individual's reputation or good name. Defamatory statements are those which tend to diminish the value or esteem in which the individual is held or could lead to social ostracism. The defamation occurs when the statement is made to others about an individual. Defamation which is written is libel; when spoken it is slander. The key element in defamation is the derogatory nature of the statement. If the statement is proved to be *wholly* true, then that is a complete defence for the maker of the statement.

For example, it is defamatory to deride a person's fitness or ability in his work ("Dr. X. is a butcher"), to state that he has committed a crime, or that he has contracted a loathsome disease. (Leprosy and venereal disease are considered "loathsome diseases" because historically they resulted in social rejection). Slander in these areas gives rise to a cause of action without requiring proof of special damage.

Truth is a legal defence to a charge of defamation. Truth is NO defence to a breach of confidentiality.

What then of the nurse who caused trouble for Sylvia and Jim? Whether or not her facts were correct, she had no right to violate the confidentiality of Sylvia and Jim by disclosing to anyone the medical attention they had sought. The nurse learned this information in the course of her employment. Even though Sylvia and Jim were *not* her patients, she still owed them a duty of confidentiality. She was under no statutory duty to inform anyone. The nurse was clearly in breach of her professional responsibility to have disclosed this information.

Recommended nursing action

- Think before you speak.
- Close the door when giving report to the next shift.
- Refrain from personal comments about patients unless they are relevant to the patient's care. If sixty-year-old Mrs. Smith is cantankerous, there may be a reason for it. But the receptionist and your friend in pediatrics don't have to know!
- Refrain from shop talk in public places, or at parties. If you *must* discuss cases, omit names and other identifying characteristics and personal remarks.
- Avoid repeating what you hear about other patients from other staff members.
- Remember the patient's diagnosis is his business. Nurses with access to "sensitive" personal information (e.g. Birth Control and VD clinics) should take special care to exercise discretion and secrecy.
- Do not discuss patients with other patients or within the hearing of other patients.
- Remember that the duty to keep information confidential applies to information gleaned from the chart.
- Good professional judgment and common sense sensitively applied are your bulwark against unwarranted disclosure.

References

- 1 *Revised statutes of Quebec* 1964. c. 252,s.50.
- 2 O. Reg. 578/75 s. 21(k) under *The Health Disciplines Act* 1974, c.47. Nursing, Part iv.
- 3 *Privacy Act* S.B.C. 1968, c. 39.
- 4 *The Privacy Act*, S.M. 1970, c. 74.
- 5 Fleming, J. *The law of torts* 5th ed. Sydney, The Law Book Company, 1977.
- 5 Sklar, Corinne. Legal consent and the nurse *Canad. Nurse* 74:3:34-37, 1978.

* References not verified by C.N.A. Library.



"You and the law" is a regular column that appears each month in *The Canadian Nurse* and *L'infirmière canadienne*. Author Corinne L. Sklar is a nurse and third-year law student at the University of Toronto.

News

RNABC recognizes role of nurse midwife

B.C. nurses, through their professional association, have moved to support recognition of the extended role of the nurse midwife in today's practice setting. A statement issued by the Registered Nurses Association of B.C. states: "The RNABC supports recognition of the nurse midwife as a health professional authorized to provide comprehensive care to mother and newborn infant during the maternity cycle. This role is consistent with other extensions of nursing practice which have already led to qualified registered nurses exercising high levels of assessment and management skills.

The qualified nurse midwife should have expertise in general nursing, as well as advanced education and training in maternal and newborn care. With this preparation, the nurse midwife will be able to:

Provide supervision, care, support and advice during pregnancy and the puerperium, including management of labor and delivery, to the low-risk mother and baby in consultation with the family's physician and other health care workers.

Provide expert nursing care to high-risk patients, under the direction of the physician.

Provide counseling and teaching related to preparation for parenthood, family planning, infant care and common gynecological problems."

The RNABC also endorses the following statement on home deliveries approved by the Western Nurse Midwives Association in November 1977:

"We as an association are aware of a growing consumer interest in home confinements but recognize that the Canadian health care delivery system is not presently developed to support this type of maternity care, i.e. back-up support services for emergencies."

Health-oriented system recommended by ANPEI

The 1,000-member Association of Nurses of Prince Edward Island has responded to the provincial government's green paper on health care, "Discussion Paper on Health Policy for Prince Edward Island," by presenting its own ideas on the changes and improvements that should be made in the health care system to provincial representatives. A list of ten specific recommendations drawn up from suggestions made by ANPEI members was attached to the association's formal response. These included recommendations that:

- the department of education and the department of health work together on developing a provincial policy on "family life education" in the school system.
- the school physical education program should emphasize fitness rather than competitive sports and programs which positively reinforce a fitness-oriented lifestyle be developed for the general population.
- use of seat belts be made mandatory through legislation and present legislation dealing with impaired drivers be more strictly enforced.
- the needs of our present users of health care facilities be assessed to determine appropriate facilities and services required to meet these needs.
- a multidisciplinary team perform periodic audits on users of the various health care facilities and services to determine if these facilities and services are being properly utilized.
- all costs of health care services, regardless of level of care, be covered under government health insurance and methods such as across-the-board per diem rates or premiums be examined with a view to providing the necessary funding.
- government be prepared to finance the educational opportunities necessary for nurses to meet the changes in the present system.

Study evaluates nurses in the North

A research study, conducted through the facilities of the University of Alberta, will investigate the care nurses are currently providing in Canada's isolated nursing stations.

The overall goal of the study is to determine if nurses who have taken a Clinical Training Program, a program sponsored by Medical Services Branch of National Health and Welfare and offered at six universities across Canada, provide different care than nurses who have not had this training. The CTP seeks to improve the clinical skills of nurses employed by Medical Services Branch who are assigned to nursing stations in the Northwest Territories, Yukon, and northern communities in the provinces. The study will also investigate how CTP graduates compare to midwives, graduates of other expanded role programs and nurses with extended experience in primary care.

The study "Comparative Field Evaluation of Nurses Practicing in Isolated Nursing Stations" is under the direction of C.B. Hazlett, associate professor in the division of health services administration at U. of A., and the research coordinator is Joy Edwards, M.Sc.N. At present, three nurses, Valerie Ann Beynon, Diana Clarke and Kerry Arlene Toll are being trained as research assistants.

The data collection phase of the project will take place from July 1, 1978 to June 30, 1979. Forty nursing stations will be randomly selected for the study. Each of the three research assistants will visit approximately 12-14 stations and whenever possible will stay within the nursing station. The evaluation will include history taking, physicals, prenatal assessment, and suturing; record review; written examinations; and a simulation exam using audiovisual material.

The final report of the study is scheduled to be completed by March 31, 1980.

Palliative Care Workshop held in Hamilton

St. Joseph's Hospital in Hamilton, Ontario was the setting for a recent workshop on palliative care. Held in early March, the one-day workshop brought health care professionals together to discuss the various problems encountered in caring for terminally ill patients.

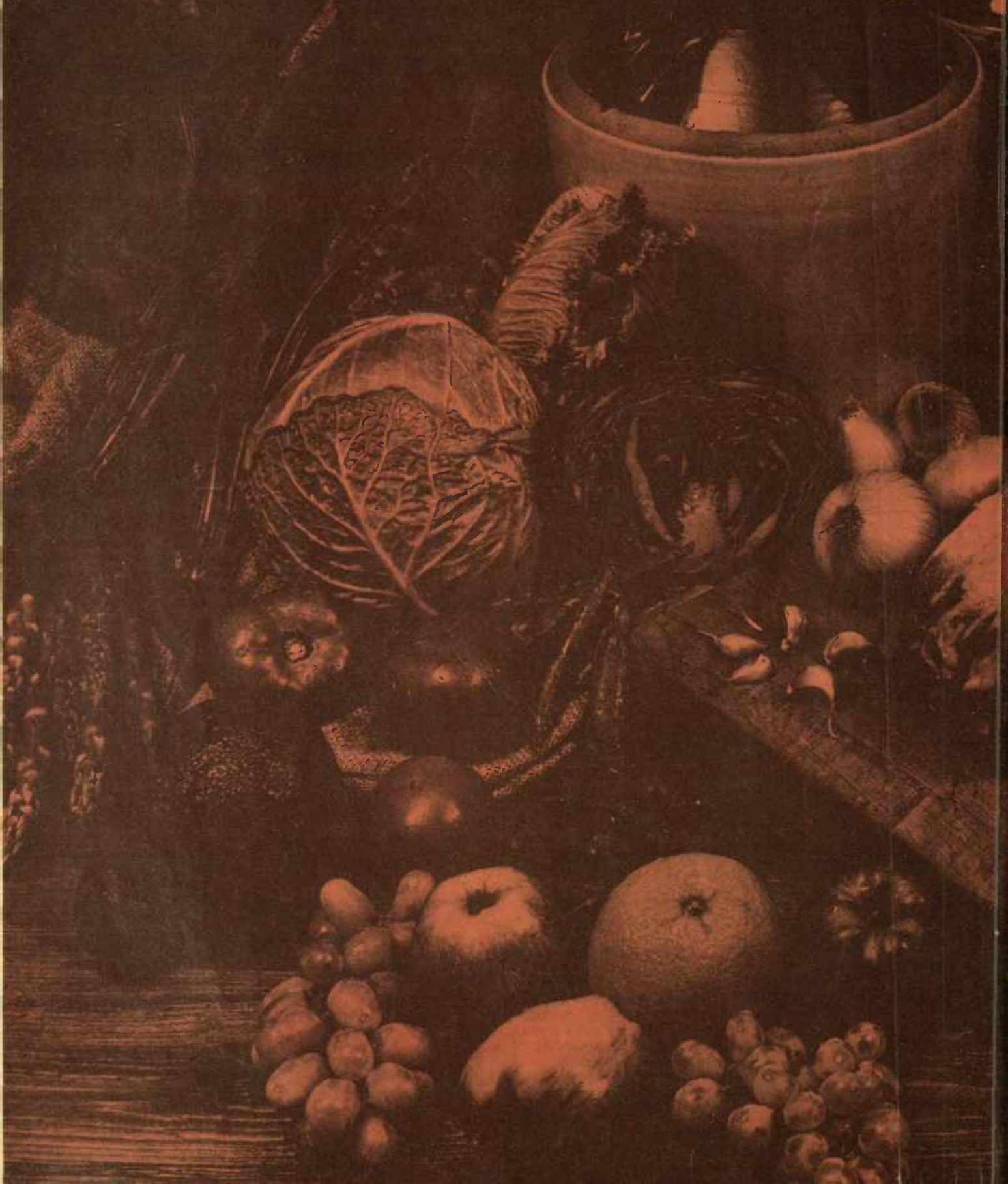
In his opening remarks, Dr. Galloway, executive director of Hamilton's St. Joseph's Hospital, stated that the hospital is investigating the possibility of establishing a palliative care unit or consultation team. "The information exchanged at this workshop will provide a starting point from which we can continue to progress," he said. The only other two hospitals in Canada with palliative care units are St. Boniface Hospital in Manitoba and the Royal Victoria Hospital in Montreal.

Dr. John Fraser Scott, keynote speaker for the workshop, described the care of the terminally ill at the Royal Victoria Hospital in Montreal, where he currently works. He discussed the five main elements of the unit: home care, palliative care unit, consultation team, bereavement follow-up and education program. He emphasized that, if at all possible, patients remain at home or return home to be cared for in a family setting.

The most important features of this type of unit are quality care for patients and effective symptom control especially control of chronic pain. Dr. Scott stressed the need to distinguish acute pain from chronic pain and to deal with the many variables which can cause pain.

There is no ideal model for palliative care, explained Dr. Scott. Rather, the model must be adapted to the patients' and the hospital's needs. The palliative care unit at the Royal Victoria Hospital is based on a model developed by Dr. Cicely Saunders at St. Christopher's Hospice in London, England.

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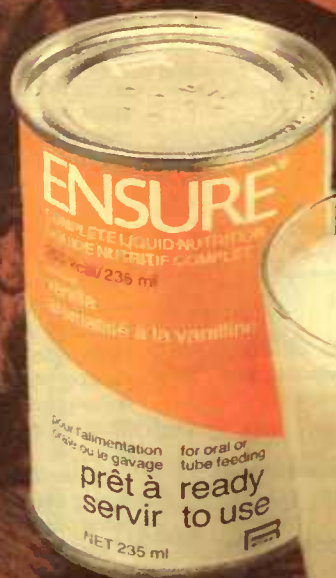


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NEWS (cont'd)

CNA directors approved the following amendments to the association bylaws for presentation to membership at the annual meeting in Toronto June 25 to 28th:

Section 4

Individual members: Any nurse who is a member in good standing of any of the associations mentioned in paragraph 3 and on whose behalf the full annual membership fee has been paid shall be an individual member of the association.

Section 47

Standing committees: The standing committees of the association shall be the following: (a) Testing Service Committee (b) Nursing Research Committee.

Section 48

Other committees: (a) A special committee may be established by the board at any time for a short or long term and may be dissolved by resolution of the board of directors. The appointment by the board shall set forth in reasonable detail the subject matter for study by the committee, its composition and such other terms as the board deems fit; (b) An ad hoc committee may be established by the board for a specific purpose on precise terms of reference which shall provide that the committee shall cease to function upon completion of the specific task. The composition and other terms of reference of the committee shall be set forth in the board's appointment.

Section 56

Whenever amendments are made to bylaws, consequential editorial changes may be made to the bylaws or rules as required.

Two other resolutions submitted by CNA members were reviewed by the board of directors and approved for presentation at the annual meeting:

Whereas, nursing education in Canada is taking a variety of directions resulting in an ad hoc proliferation of types of programs and practitioners;

Whereas, there are continuing changes in student populations and demands of consumers in regard to nursing education programs;

Whereas, the trends in registration/licensure, credentialing, development of standards of nursing education and nursing practice, the changing nature of specializations in nursing and moves toward accreditation all have implications for nursing education; and

Whereas, there has not been an opportunity for nurses from the provinces and territories to discuss issues and share problems as they arise on a national basis; be it

RESOLVED, that CNA take leadership in convening a national conference to enable nurses to address concerns related to the development of nursing education programs, diversity of "specialized" practitioners and current issues and problems accompanying these developments; and further, be it

RESOLVED, that a future conference be considered to include employers, consumers of nursing care, national, provincial, and territorial nurses associations, and government planners.

Whereas, every Canadian citizen has the right to expect assistance in maintaining optimum health through expert health teaching;

Whereas, many Canadian citizens lack a basic understanding of the importance of and methods for maintaining health; and

Whereas, national television programming can be valuable educational tool which reaches the majority of Canadian citizens;

RESOLVED, that the Canadian Nurses Association request that the federal government give consideration to the need for additional programs on the Canadian Broadcasting Corporation network designed to educate the public on preventive health care.

CNA directors hold Spring session

Directors of the Canadian Nurses Association attended a Spring meeting at CNA House in March. Highlights of the two-day meeting included approval of the association's zero growth budget for the current year, a review of plans for the annual meeting and convention in Toronto in June, acceptance of the final report of the CNA ad hoc committee on standards of nursing education and a review of the composition and qualifications of the association's special committee on nursing research.

Directors also acted to accept a request from the Canadian Nurses Respiratory Society for affiliate membership in the CNA and approved a motion urging the federal government to ratify the recent convention of the International Labor Organization concerning "Employment and Conditions of Work and Life of Nursing Personnel."

Directors requested that the Minister of Labor be informed that the organized nursing profession of Canada considers ILO Convention 149 and Recommendation 157 "of great importance in the work towards a general improvement with regard to the possibilities for health service personnel to exercise an adequate service to humanity."

The convention and recommendation were passed at the 63rd session of the ILO conference last June. To date, four nurses associations have passed similar motions requesting their provincial governments to support the convention.

Committee on Nursing Research

On the basis of a report from the members of the special committee on nursing research, directors approved a motion that would see members of the committee on nursing research appointed by the CNA Board of Directors from nominations submitted by association members and/or groups of at least ten individual CNA members.

Qualifications would include: capability in research design and methodology, evidence of activity in nursing research inclusive of clinical nursing research and ability to facilitate/influence nursing research policy.

Members will be appointed during the Fall on the basis of the goals and priorities of the CNA Board of Directors and will begin their two-year term of office on January 1st.

1978 budget approved

Directors accepted an audited financial statement for 1977 indicating a deficit of \$151,362. and approved a zero growth operational budget for 1978. Combined with a membership fee increase effective January 1978,

the zero growth budget is designed to reverse the deficit level of operation to a "finish in the black" situation by the end of the current year.

Another economy measure approved by directors was a CNA House Expansion Fund set up to accumulate monies so that eventually all CNA operations can be brought under one roof, thus eliminating the existing duplication of overhead and administration costs.

Standards for Nursing Education

The chairman of the association's ad hoc committee on standards for nursing education, Dr. M. Josephine Flaherty, presented the committee's final report which will be available from CNA by July 1.

C.V.A.'s studied



Nearly a quarter of all patients admitted to Canada's only acute stroke unit are diabetic and almost 60 per cent have high blood pressure. Those with a family history of both strokes and heart attacks run an additional risk of having a stroke.

These are just some of the data included in the third annual report of the MacLachlan Stroke Unit, a multidisciplinary unit at Sunnybrook Medical Centre, University of Toronto, that specializes in the diagnosis, treatment and rehabilitation of those patients who have suffered cerebral accidents.

The report outlines the unit's three years of operation during which more than 900 patients have been admitted to their five-bed intensive care facility.

Those associated with the unit hope that the stroke treatment and allied research programs will continue to add new knowledge about the causes and prevention of the stroke condition — the third largest killer in Canada and the commonest cause of chronic disability.

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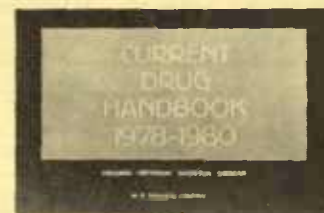
1 148 pp. 139 ill., including 16 color plates. March 1978.

Flexible binding, thumb-indexed: \$19.00.

Hardbound, not thumb-indexed: \$15.65.

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CURRENT DRUG HANDBOOK 1978-1980

Completely updated for 1978, this handy reference lists over 1,500 drugs — giving their generic and major trade names, sources, dosages, uses, action and fate, toxicity, contraindications, and interactions — all in an easily accessible tabular format.

By **Mary W. Falconer**, RN, MA; **H. Robert Patterson**, PharmD; **Edward A. Gustafson**, PharmD; and **Eleanor Sheridan**, RN, MSN. 312 pp. Soft Cover. About \$8.40. March 1978.

Order #3568-7.

REALITIES IN CHILDBEARING, A New Book

This new text presents maternity nursing in a socio-cultural context, reflecting today's realities in pregnancy and family life. You'll find detailed coverage of normal labor and delivery and care of the high-risk mother and infant, plus fascinating discussions of today's most controversial issues in maternity nursing.

By **Mary Lou Moore**, RN, MA. About 770 pp., 220 ill. About \$17.95. Just Ready.

Order #6497-0.

STRUCTURE AND FUNCTION IN MAN, New 4th Edition

The new edition of this basic text has been vastly improved by the addition of expanded physiology sections and a new physiologist author, more clinical applications, and a new chemistry appendix. An Instructor's Guide is available.

By **Stanley W. Jacob**, MD, FACS; **Clarke Ashworth Francone**; and **Walter J. Lassow**, PhD. About 680 pp., 535 ill., 155 with color. About \$17.85. Just Ready.

Order #5098-8.

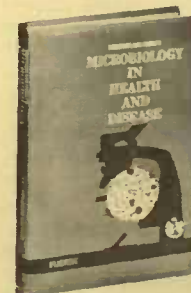
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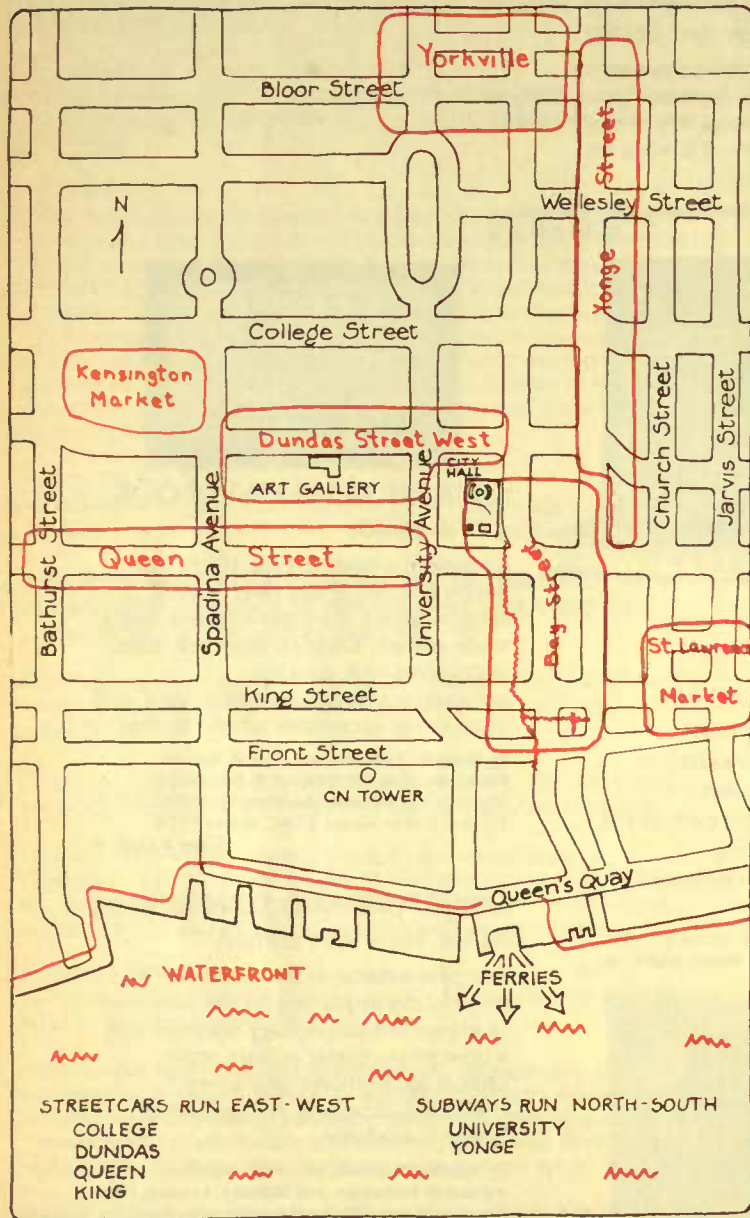
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Canadian Nurses Association

Toronto, June 25-28



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(Reprinted from "The Insider's Guide to Toronto," by Glenn McInnes, published by Piccadilly Press, 1977, and available in Toronto bookstores or by writing to Box 98, 514 Piccadilly Avenue, Ottawa, Ontario, K1Y 0H8. Price \$6.95).

Convention notice board

Hear it right! Right away!

For the convenience of delegates, all major presentations during the convention will be recorded on cassette tape and made available at \$7.00 each by Audio Archives. It's fast, it's economical and it will add to your professional growth.

McMaster Health Sciences Centre Tour

Thursday, June 29, 1978
Come to Hamilton, Ontario, after the CNA meeting. The health agencies of Hamilton, Ontario invite you to visit some of their excellent clinical and educational facilities. You will be bused from Toronto to Hamilton, visit the McMaster University Health Sciences Centre and after lunch have an opportunity to see and discuss a clinical/educational area of your choice. Areas available include: educational programs, diploma and baccalaureate levels in primary care nurse educational programs, specialty care clinical units and extended and home care agencies. The cost of \$12 includes transportation and meals. For information contact: Isabel Kay, Coordinator of Program for Post-CNA Visit, McMaster University Medical Centre, 1200 Main St. W., Hamilton, Ont. L8S 4J9.

Nursing Sisters Association of Canada

Biennial meeting; Tuesday, June 27, 1978 at 14:00 hours; B.C. room, Royal York Hotel. Reception and dinner; 18:30 hours, The Boulevard Club, Lakeshore Blvd.

For information contact: Miss Ella Beardmore, 1026 Kennedy Road, Scarborough, Ontario, M1P 2K6.

Reunion breakfast

The alumni association of the University of Toronto faculty of nursing will host a reunion breakfast on Tuesday, June 27. Details available from the hostess desk during the convention or by writing to: Shirley Davey, 40 Alexander Street, Apt. 504, Toronto, M4Y 1B5.

Department of Public Health Nursing

Plan to visit the City of Toronto's Department of Public Health Nursing while you are in Toronto. Contact Betty Davidson, director of nursing, or Florence Bonyun, educational consultant, City of Toronto, Department of Public Health Nursing, Nursing Division, 8th floor, East Tower, City Hall, Toronto, M5H 2H2. Telephone 416-367-7443.

Nurses Christian Fellowship

Speaker: Muriel Wilson, R.N., M.Sc. Topic: "Personal integrity in ethical decisions"
Place: The Algonquin Room, Royal York Hotel,
Time: June 26, 1976, 20:00 hours.
Tickets: \$2 at the door; students free.

Continental breakfast

Place: The Alberta Room, Royal York Hotel,
Time: June 27 and 28, 1978, 07:45 hours.
Tickets at \$2.75 available from IVCF—Ontario division, 745 M Pleasant Rd. Toronto, Ontario M4S 2N5.

Calendar

June

Call for papers for the National Conference on Nursing Research to be held on December 13-15, 1978 in Winnipeg, Manitoba. Papers which describe problems, issues or innovations in methodology in nursing care research are invited from nurse researchers. A limited number of papers on historical research, development of nursing theory, research in education or administration will be considered. Completed papers must be postmarked June 10, 1978. Contact: *Dr. Helen Glass, School of Nursing, University of Manitoba, Winnipeg, Man. R3T 2N2.*

Canadian Association of Neurological and Neurosurgical Nurses Annual Meeting to be held on June 21-23, 1978 at the Hotel Sheraton Landmark in Vancouver, B.C. Contact: *Pauline Weldon, Secretary, CANNN, 25 Lawson Ave., Dartmouth, Nova Scotia, B2W 2Z2.*

80th Annual Meeting of the Victorian Order of Nurses for Canada to be held on June 1-2, 1978 in Thunder Bay, Ontario. Contact: *Victorian Order of Nurses for Canada, 5 Blackburn Ave., Ottawa, Ontario, K1N 8A2.*

Canadian National Operating Room Nurses Convention to be held in Halifax, N.S. on June 5-8, 1978. Contact: *Elizabeth Clinton, R.N., Chairman, Publicity and Advertising Committee, 2104 - 1333 South Park St., Halifax, N.S., B3J 2K9.*

41st Annual Meeting of the Canadian Ophthalmological Society to be held on June 11-15, 1978 at the Hotel Nova Scotian, in Halifax, N.S. Highlights include workshops on glaucoma, diabetic retinopathy, care of patients with contact lenses. Contact: *COS 1978 Annual Meeting, Dr. G.J. Whiston, 402-6389 Coburg Road, Halifax, N.S. B3H 2A5.*

Annual Meeting of the Canadian Lung Association, the Canadian Thoracic Society and the Canadian Nurses' Respiratory Society to be held on June 12-14, 1978 at the

Holiday Inn, Winnipeg Convention Centre. Contact: *Hubert Drouin, Executive Secretary, Canadian Lung Association, 75 Albert St., Suite 908, Ottawa, K1P 5E7.*

July

Infection Control Conference sponsored by the Canadian Hospital Infection Control Association to be held July 5-9, 1978 at Jasper Park Lodge in Alberta. Contact: *Shirley Chewick, 125 Russell Avenue, Ottawa, K1N 7X2.*

September

Post Diploma Maternity Nursing Course. A twelve-week course designed to prepare nurses to give optimum maternity care in hospital and the community. Commencing September 4, 1978 in Halifax, N.S. Contact: *Director of Nursing Education, Grace Maternity Hospital, 5821 University Ave., Halifax, N.S. B2H 1W3.*

Post Diploma Neonatal Intensive Care Course. A twelve-week course open to nurses with neonatal nursing experience beginning September 4, 1978 in Halifax, N.S. Contact: *Director of Nursing Education, Grace Maternity Hospital, 5821 University Avenue, Halifax, N.S. B2H 1W3.*

5th Annual Meeting of the Ontario Psychogeriatric Association to be held on Sept. 25-27, 1978, in London, Ontario. Theme: Psychogeriatric care in institutions and in the community. Contact: *K.G. Csapo, London Psychiatric Hospital, P.O. Box 2532, Terminal "A", London, Ontario, N6A 4H1.*

13th Annual Conference of the Canadian Addictions Foundation — Call for papers. To be held on Sept. 24-29, 1978 in Calgary, Alberta. Contact: *Stuart Hutton, Alberta Alcoholism and Drug Abuse Commission, 812-16 Ave. S.W., Calgary, Alberta, T2R 0T2.*

Care of the Child with Cancer.

Sponsored by the American Cancer Society to be held on Sept. 11-13, 1978 at the Sheraton-Boston Hotel in Boston, Mass. No registration fee. Contact: *Sidney L. Arje, M.D., American Cancer Society, National Conference on the Care of the Child with Cancer, 777 Third Ave., New York, New York, 10017.*

First Ontario Annual Assembly of Emergency Care to be held at the Skyline Hotel in Toronto on September 11-13, 1978. Sponsored by the Association of Casualty Care Personnel, Emergency Nurses Assoc. of Ontario and Ontario's Emergency Physicians. Contact: *M.G. Hutchison, Assistant Director of Nursing, The Mississauga Hospital, 100 Queensway West, Mississauga, Ontario L5B 1B8.*

36th Annual Convention and Educational Programme of the Canadian Health Record Association at the Skyline Hotel in Ottawa, on September 30-October 4, 1978. Contact: *Janet Milner, Executive Director CHRA, 187 King St. East, Oshawa, Ont., L1H 1C3.*

October

Stroke Rehabilitation Conference to be held on Oct. 20-21, 1978 at the Royal Connaught Hotel, in Hamilton, Ontario. Those wishing to present an original paper on any aspect of stroke rehabilitation should submit a 100-word abstract by July 31, 1978 to: *Dr. Murray Brandstater, Chedoke Rehabilitation Centre, P.O. Box 590, Hamilton, Ontario, L8N 3L6.*

Cancer Update — A Symposium for Nurses and other Health Professionals to be held on Oct. 11-13, 1978 in Birmingham, Alabama. Sponsored by: American Cancer Society, University of Alabama School of Nursing, UAB Comprehensive Cancer Center. Fee: \$40. Contact: *Judy E. White, Adm. Sec., UAB Comprehensive Cancer Center, Birmingham, Alabama, 35294.*

The Critical Years: Some New Perspectives. An international conference sponsored by the Canadian Association for Young Children to be held on Oct. 12-15, 1978 at the Winnipeg Convention Centre, Winnipeg, Manitoba. The conference will focus on the development of healthy children and support systems for young children in the family. Contact: *The Canadian Association for Young Children, P.O. Box 38, Postal Station "C", Winnipeg, Manitoba, R3M 3S3.*

Did you know ...

The Nursing Division of George Brown College in Toronto has centralized all of their **post-diploma and upgrading programs** for nurses in a new location at Nightingale Campus.

Along with the popular refreshers or upgrading modules, this new department is also offering continuing education programs in Child and Family Mental Health, Critical Care, Long-Term Care, Neonatal Intensive Care, Rehabilitation, and O.R. Nursing.

Some, like the evening upgrading course in Pharmacology, are available part-time. Most are full-time intensive theory and practice. At least one program is experimenting with adaptations in order to accommodate working nurses who want to update knowledge and skills but have difficulty obtaining leaves-of-absence from employers facing staff shortages.

Nurses interested in more details regarding these programs or having suggestions for other areas of need in continuing education may contact: *Nightingale Campus of George Brown College, P.O. Box 1015, Station B, Toronto, Ontario. Telephone 416-967-1212, Local 700.*

The funny side

A doctor's new secretary was having trouble with her notes on a case which read: "Shot in the lumbar region."

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More about Skateboards



Last month, *Here's How* featured a description of the skateboards used at Children's Hospital of Eastern Ontario to allow children in hip spicas to be a little more independent.

Here's a little more information on the skateboards: Children with fractured femurs and various orthopedic surgeries are often confined and immobilized in casts for an extensive period of time. As soon as the cast is applied, we mobilize our children by placing them on a skateboard or scooter that we designed.

The scooter is triangular in shape and has shepherd casters on the bottom so that corners can be easily manipulated. The child is placed lying on his abdomen with his head at the narrow end of the scooter and his legs supported at the broad end. He is then able to propel himself freely with his arms.

A rope attached to the narrow end of the scooter may alternately be used to pull the scooter from one destination to another. The meal tray, school work, crafts etc. can be placed on the floor in front of the child. We also lend a limited number of the scooters to parents when their child is discharged and they return them to us when they bring him back for cast removal. Onwards and upwards to independence.

— Margaret Wagner, Clinician II- 5 East, Children's Hospital of Eastern Ontario, Ottawa, Ontario.

Here's How

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I have found that bedsores respond well to the following treatment: Apply warm saline compresses to the affected area for half an hour every three hours. Then apply tincture of benzoin and expose the area to the air or oxygen for five minutes. Follow this procedure until healing has taken place. Continue to use foam pads under drawsheets and between bony areas.

— Sister Bertha M. Samson, R.N., private duty nurse, Moncton, N.B.

Lean on Water

Elderly people and patients confined to a wheelchair often develop pressure sores from leaning against the armrest for support. To reduce the pressure, partially fill a small hot water bottle with water and place it on the armrest. It makes a handy cushion that's just the right size.

— Sr. T. Kilfoil, R.N., Rocmaura Nursing Home, Saint John, N.B.

Every nurse has practical ideas gathered from his or her experience on how to make life a little easier for nurses and for patients. *Here's How* is a column for you and your ideas. If you have an original and practical suggestion that you think might help other nurses to improve any aspect of patient care, why not share it with other nurses? We'll send you \$10. for any suggestion published. Let's hear from you. Write: The Canadian Nurse, 50 The Driveway, Ottawa, Ontario, K2P 1E2.

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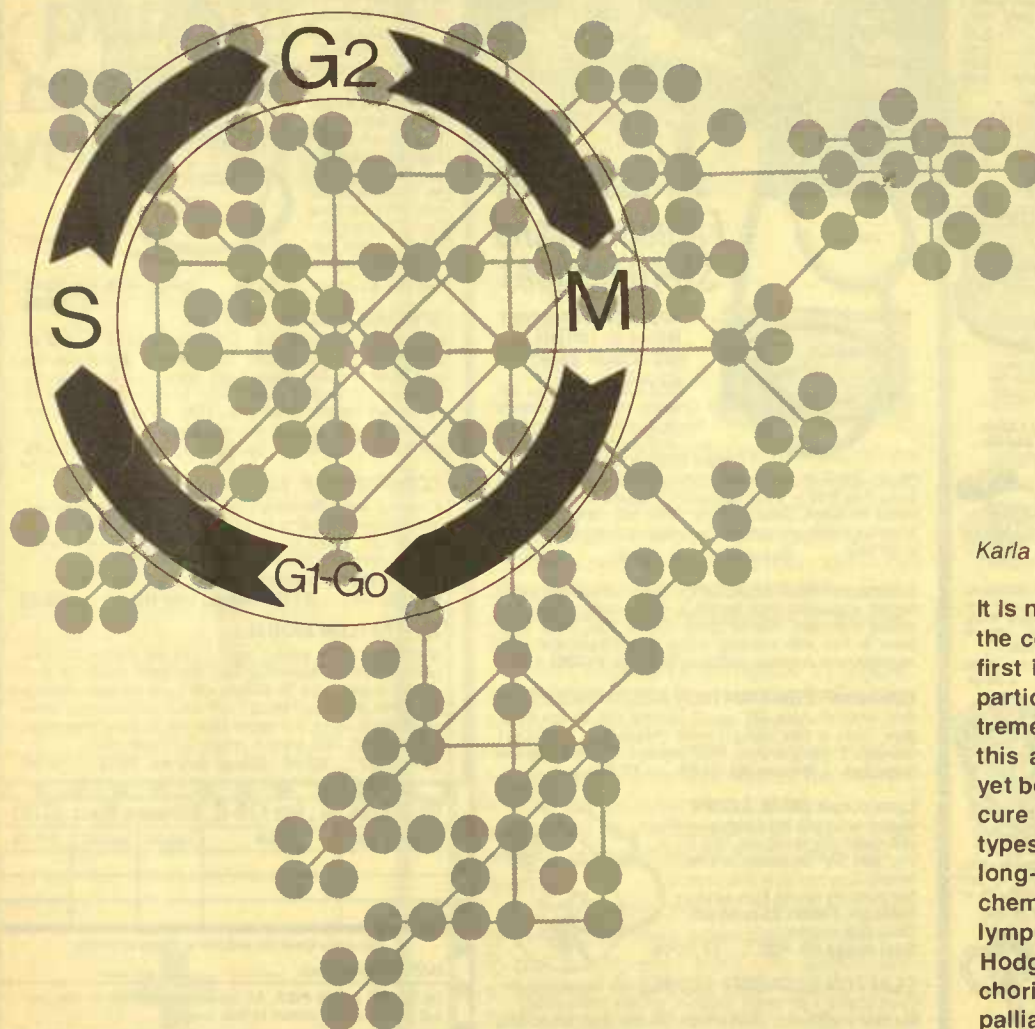
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The patient receiving chemotherapy presents an educational challenge. Unless you help him to understand what is happening during the course of treatment, your patient may well become the victim of needless fear and apprehension.

the stress of chemotherapy



Karla Rose

It is now more than a hundred years since the concept of cancer chemotherapy was first introduced. Since 1854, but particularly in the last 25 years, tremendous advances have been made in this area and now, although no drug has yet been discovered that will effect a total cure of malignant processes, at least ten types of neoplasms can be put into long-term remission by the use of chemotherapy. Among these cancers are lymphocytic leukemia, Wilms' tumor, Hodgkin's disease and gestational choriocarcinoma in women. The former palliative role of chemotherapeutic agents has changed and now these drugs are being used to improve general well-being, prolong life and in some cases even effect a cure. There is a wide variety of drugs that can be used either alone or in combination and/or to complement the therapeutic use of radiation, surgery and immunotherapy in the treatment of cancer.

For many patients, chemotherapy brings hope. But at the same time, most antineoplastic drugs when used in therapeutically effective doses are likely to be highly toxic and produce many undesirable side effects. The treatment is often unpleasant and can easily lead to fear and misunderstanding. As a nurse you are in an excellent position to observe the patient, to monitor the side effects he may experience and to explain what is happening to him and why.

At the cellular level

All cells, whether malignant or normal, replicate in a dynamic cyclical fashion. They follow the four phases of the cell life cycle:

1 GO and G₁

The G₀ phase refers to the cell's resting period. Cells may remain in this phase until a stimulus such as the death of another cell in the same group or population occurs. With such activation, the G₁ phase begins and the cell will:

- synthesize protein;
- synthesize RNA;
- mature physically in size to finally enter into the S phase of the cell life cycle.

2 S Phase

The production or synthesis of DNA occurs during this phase. DNA, the carrier of the cell's genetic code, is found in the nucleus of each cell. It is responsible for regulating certain vital functions such as cell specialization, cellular mobility and cellular division. Malignant cells differ from normal cells in that they divide, mobilize and differentiate uncontrollably. This has led some researchers to believe that the pathology of cancer refers to a disorder in DNA, producing cellular derangement.

3 G₂ Phase

This phase follows the completion of the S phase. Little is known about the cell's metabolic activity during this time, but one theory suggests that RNA is produced.

4 M Phase

There are four stages in mitosis, the process of cell division. They are: prophase, metaphase, anaphase and telophase. At the completion of the four stages, the cell divides to produce two daughter cells. Each daughter cell is supplied with genetic information and has the potential for maturation and repetition of the cell life cycle. If the daughter cells do not actively reenter the cell life cycle, they will rest in the G₀ phase to await activation.

The amount of time that is required for one cell to repeat the cell life cycle is named the generation time. Some cells within the body have a rapid generation time and so grow rapidly and have a short life span. These include bone marrow cells, gastro-intestinal cells, hair follicles and reproductive cells, all of which are particularly affected by antineoplastic drugs. (See Table 1).

Table 1

Type of Cells	Generation Time
1. Bone Marrow	6-24 hours
a) Platelets	
b) White Blood Cells	
c) Red Blood Cells	
2. Gastro-Intestinal	12-24 hours
3. Hair Follicle	24 hours
4. Reproductive Cells	24-36 hours

Drug action

Chemotherapeutic agents can have an effect on any cell in the body, whether that cell is malignant or normal. The absorption and transport of the drug to a particular body cell is dependent on many factors, including the patient's age and weight, nutritional status, general health status, type of malignancy and the route of administration. However, due to their cytotoxic properties, antineoplastic drugs have their greatest effect on young, rapidly multiplying cells. Their potent effect is exerted by interfering with specific cell cycles (cell cycle specific) or by potentiating cellular derangement and thereby precipitating cellular death.

The major disadvantage of chemotherapy lies in its lack of selective toxicity. This means that chemotherapeutic agents not only affect malignant cells but also destroy rapidly dividing normal cells (i.e. cells with a rapid generation time). This destruction of malignant as well as non-malignant cells accounts for the toxic symptoms attendant to the use of most chemotherapeutic agents. For example, the rapidly dividing normal cells which are injured or destroyed by chemotherapy are:

- the **bone marrow cells** with a generation time of 6-24 hours. Damage or destruction to these cells can result in erythropenia (anemia), leukopenia (immunosuppression) and thrombocytopenia (decreased clotting efficiency). The stress of chemotherapy is exhibited in bone marrow function 4-14 days after the first dose. Bone marrow depression reaches its peak at 7 to 14 days. Side effects may be observed for several weeks after the drugs are discontinued. This happens because different cells have varying life spans — red blood cells can remain circulating for 120 days; white blood cells, 12-24 days; and platelets 2-3 days.

- the **gastro-intestinal epithelium** is readily affected by chemotherapy. The patient receiving chemotherapy may develop mucositis, xerostomia, stomatitis, ulcerations, esophagitis, nausea, vomiting, anorexia, diarrhea, dyspepsia, dysphagia, dysgusia, and G.I. bleeding.
- **hair follicles** replicate at a slightly less aggressive rate, approximately every 24 hours. A manifestation of trauma and/or destruction of these cells includes progressive alopecia to complete loss of hair.
- cells of the **reproductive system** divide every 24 to 36 hours. Effects of chemotherapy upon these cells will result in aspermatozoa in the male and amenorrhea in the female.

Toxins that are released in the body from the destroyed cells must be detoxified and removed by the liver and kidney. This often results in an elevated BUN, hyperkalemia and possibly hypercalcemia.

Nursing Implications and Side Effects

The patient receiving chemotherapy requires knowledgeable nursing care that includes patient education. The more the patient knows about his condition and his treatment, the more cooperative and less anxious he will be. Your role as educator is to provide him with information about his treatment and the possible side effects that may occur. Although many pamphlets and booklets are now available for the patient receiving chemotherapy¹ these should complement your teaching rather than act as a replacement for it.

1. Bone Marrow Depression

Leukopenia

White blood cell depression can begin between the 4th and 14th day after the initiation of chemotherapy. This can be a life-threatening side effect of cancer chemotherapy and consequently the patient must be carefully monitored. Nursing care on every shift should include routine assessment for physical and emotional manifestations of infection along with changes in vital signs. Frequent blood counts must be done to determine the patient's response to the drugs and to assess for leukopenia.

If the WBC level approaches 3,000/mm or below, the drug therapy should be re-evaluated or discontinued. If severe leukopenia develops, reverse isolation should be considered for the patient since leukopenia with secondary severe immunosuppression represents a very serious complication.

Reverse isolation procedure should include the following:

- meticulous handwashing;
- sterile gloves, gown, mask and cap;
- sterile trays;
- frequent housekeeping by the nurse.

As well, no rectal temperatures should be taken, minimal I.M. injections should be

given and other measures should be started to maintain the patient's skin integrity.

A patient on isolation will require more intense emotional support as well as frequent reinforcement and explanation about reverse isolation procedures. Explain to him that such precautions will be necessary only until his WBC count elevates (WBCs are the first cells of the bone marrow to regenerate normal cells) or until chemotherapy is discontinued. A leukocyte transfusion may also be considered at this time.

Thrombocytopenia

A decrease in the number of blood platelets increases the hazard of hemorrhage from the cerebrum, gastro-intestinal tract and the renal system. Signs of thrombocytopenia are bleeding gums, epistaxis, ecchymoses, petechiae, hemoptysis, hematuria, hematemesis, hematochezia and uncontrolled bleeding. The patient should be aware that these signs are important and that he must report them immediately.

If the patient's platelet count falls below 50,000/mm reverse isolation should be initiated. All stools, urine, vomitus and sputum should be tested for blood, and no I.M. injections should be given. A note should be made on the nursing history identifying the medications the patient is presently receiving and cautioning against prescribing drugs such as aspirin, alcohol containing medications, cough medicines or anti-coagulants, all of which aggravate defective blood clotting mechanisms.

Platelet transfusions should be considered if the count is below 50,000/mm but this is only a temporary measure since the effectiveness of platelets in the bloodstream is only of 2-3 days duration. The platelet count will return to normal after chemotherapy is discontinued.

Erythropenia

A patient with decreased erythrocytes will experience lassitude, lethargy, shortness of breath, dyspnea, skin pallor, hypochromic palpebral conjunctiva, decreased capillary refilling and anginal pain. If the hematocrit falls below 25%, the patient should receive transfusion of packed red blood cells and should be encouraged to eat a diet high in iron. Nursing care should be based on the patient's ability and the degree to which he is able to carry out the activities of daily living.

2. Gastro-Intestinal Irritation

Stomatitis

The key here is prevention. Prophylactic mouth care should be started prior to or with the onset of chemotherapy. The patient should wash out his mouth every 2-3 hours using a warm solution of hydrogen peroxide and normal saline (1:1 solution).

Mouthwashes should not be used as they eliminate normal mouth flora, precipitating fungal (monial) infections. A soft toothbrush or sterile cotton swabs should be used along

with dental floss. Dentures should be used with careful judgment as they may cause irritation and encourage growth of organisms. Lips should be well lubricated with neosporin or sterile vaseline. If any evidence of stomatitis lesions are found on physical examination, rinsing every 2-3 hours with nystatin or mycostatin suspension may eliminate the causative organisms.

The diet should be soft, avoiding extreme temperatures, spices, and herbs. Meals should be offered in small, attractive portions at frequent intervals. This may aid in eliminating other possible side effects such as dyspepsia, dysgusia, anorexia, esophagitis, and dysphagia. The pain of oral stomatitis may be relieved by viscous zyllocaine or dyclone.

Nausea and Vomiting

This commonly occurs two hours after drug administration. These symptoms may be severe for twelve hours and then completely diminish within twenty-four hours. Often, the patient will require an antiemetic to relieve the symptoms.

3. Hair Follicles

Alopecia

Hair loss represents a severe threat to the body image of the patient receiving chemotherapy. Recently, a new theory to decrease hair loss has been utilized in some hospitals. Tourniquets are applied to the scalp one minute prior to drug administration and are left on until five minutes after administration. However, this technique should be used with caution since the danger of micrometastasis to the brain is a potential danger to the patient.

If the patient has long hair, it might be helpful to have it cut short to minimize the rapidity and trauma of hair loss. Prior to complete hair loss, wigs should be purchased, slightly smaller than the size required at the time of purchase. Explain to the patient that his hair will grow back once chemotherapy is discontinued (sometimes even during chemotherapy administration). Often, the hair grows in faster, slightly thicker and possibly with more curls and waves than before. As well as scalp hair loss, other areas of epilation include the eyebrows, eyelashes, skin hair and genital hair. Cosmetic aids such as an eyebrow pencil and false eyelashes may help the patient cope with this change.

4. Reproductive suppression

Aspermatozoa in the male patient and amenorrhagia in the female will generally be corrected upon the discontinuance of chemotherapy. Both male and female patients should continue contraceptive practice if desired since the sperm may remain potent in the male with the potential for fertilizing the ovum, while in the woman,

although not actively menstruating, there may have been an ovum produced with the potential capacity to become fertilized.

Conclusion

The patient receiving chemotherapy offers many challenges to nursing. Numerous opportunities exist for collaboration with other members of the health care team to meet the needs of the patient. The nurse's role is multi-dimensional as she actively supports, nurtures, counsels and educates the patient while minimizing the complications that may arise. ♡

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Rose received her Master's degree in nursing at Boston University School of Nursing and is currently pursuing her doctoral degree in counseling at the Boston University School of Education. Other articles by Karla Rose have appeared in various publications including the *American Journal of Nursing*.

FOUR BASIC STEPS TO SUCCESSFUL PATIENT TEACHING

Mr. Johnson had been on anticoagulants before, so he had some idea of why he needed them and how they worked. But when I found out that he had been biting off half a pill now and then, whenever he thought it necessary, I realized that he still had a lot to learn.

Denise Talarico

No nurse denies the importance or the challenge involved in patient teaching. But when it comes right down to it, many of us still cringe at the thought of planning or carrying out teaching functions. Is it because we subconsciously consider the learning process to be very complex, involving an impossible amount of time and energy on our part? Or do all those theoretical teaching models leave us too far removed from what we consider reality?

As a nursing student, I certainly felt overwhelmed by the responsibility involved in teaching patients. These feelings began to change, however, when I was introduced to some concrete guidelines for patient

teaching derived from the problem-solving approach inherent in the nursing process. I found that by following four basic problem-solving steps, I was able to plan and successfully carry out formal and informal teaching sessions. These four steps are:

- identification of patient learning needs
- setting of patient goals;
- selection of teaching methods (with consideration of teaching and learning principles);
- evaluation.

In the final quarter of my basic nursing education, I was able to test this approach in a clinical situation.

STEP 1

Patient Learning Needs

Mr. Johnson was a 60-year-old man with a diagnosis of thrombophlebitis. During his stay in the hospital, he was receiving 6,000 I.U. of heparin every six hours by intermittent intravenous infusion. A daily dosage of dicumarol was also started during his hospitalization.

When I met Mr. Johnson, his doctor had already told him that his heparin would soon be discontinued, but that he would have to continue his daily dicumarol when he went home. Because he had previously taken the drug at home, Mr. Johnson already had a fair understanding about why he needed it and how it worked. He told me however, that he hadn't really had any formal teaching about oral anticoagulants, and that most of his knowledge about them stemmed from personal experience.

He told me, for example, that he knew he had taken too much dicumarol when his nose started bleeding. His wife added that he was a good judge of the amount of medication he needed; he "bit off half a pill here, and half a pill there, when necessary. These remarks made it quite evident to me that Mr. Johnson had definite learning needs about anticoagulant therapy.

When I asked him whether he would like to review some facts about his medication he agreed that it would be a good idea. As we talked together, we were able to identify some of his learning needs, including the importance of adherence to prescribed dosage levels, the purpose and importance of prothrombin time tests, signs and symptoms of anticoagulant overdose and measures that he should take while on dicumarol.

STEP 2

Learning goals

Our talk together enabled us to develop five specific learning goals for Mr. Johnson. After teaching sessions, we felt that he should be able to:

- state the importance of following the prescribed drug dosage and relate the reasons for adherence;
- state the purpose and importance of regular blood prothrombin time tests;

- state the reason for close contact with his doctor regarding these results;
- state measures to be taken in case of overdose and bleeding;
- state precautions he should take while receiving anticoagulant therapy (for example avoidance of ASA, avoidance of excessive Vitamin K in the diet, avoidance of trauma, and the importance of having a medic alert tag or card).

STEP 3

Teaching Method

As I planned my teaching session with Mr. Johnson, I found it helpful to keep several learning and teaching principles in mind. (See Figure 1) To begin, I had to find out exactly what Mr. Johnson knew so that we could build on his experience.

Mr. Johnson was an alert, intelligent man who had a good understanding of his condition, and basic knowledge about his medication regime. These factors led me to plan an informal discussion with an emphasis on patient input, rather than a structured lecture-type session.

To begin, I asked Mr. Johnson several open-ended questions, such as "Can you explain how you've been regulating your dicumarol dosage at home" or "How have you been communicating with your doctor?" Because such questions require more than yes or no answers, I was able to elicit some important information. For example, Mr. Johnson told me that he regulated his dicumarol according to how he was feeling — if his legs ached, he would take more medication.

This type of communication helped me to identify the client's specific learning needs, and enabled him to become aware of his lack of knowledge in certain areas, aware that there were things he needed to know. It also helped me to base my teaching on what he already knew, and formulate a specific plan of action.

On the day after our first meeting, Mr. Johnson and I reviewed the learning needs that we had identified. Then I gave him some short explicit explanations to help him meet the planned learning goals. Throughout the session, I paused frequently and asked Mr. Johnson to relate information back to me, inviting his participation in the learning process.

Generally, my explanations were kept short because Mr. Johnson already had fair knowledge of the subject matter. By using these short explanations and encouraging Mr. Johnson's participation, the session maintained a relaxed and informal atmosphere.

After talking about signs and symptoms of anticoagulant overdose and measures to be taken in case of overdose, I asked Mr. Johnson to summarize what I had told him. Because this topic was somewhat more detailed than others we had discussed and because it was so necessary to his self-care, I wanted to make sure he had a grasp of the most important points.

I found out that Mr. Johnson had never considered wearing a medic alert tag or carrying a card. When we discussed it however, he agreed that having the identification was important and expressed interest in obtaining the address of the medic alert foundation. I gave him the address, hoping that because he had something concrete, he would be more likely to follow it through.



Figure 1

Principles of Learning and Teaching

"Learning is more effective when it is in response to a felt need of the learner."¹

"New learning must be based on previous knowledge and experience."²

"Organization promotes retention and application of learning."³

"Active participation on the part of the learner is essential if learning is to take place."⁴

"Repetition strengthens learning."⁵

STEP 4

Evaluation

To assess what Mr. Johnson had learned, I used broad statements and open-ended questions. I found that he had become aware of the importance of taking the prescribed amount of medication each day. By the end of the session, he had stated several times that he would concentrate on taking the prescribed dosage every day. He was also able to relate several correct reasons for the importance of following this regimen. He mentioned the importance of maintaining a constant blood level, thus preventing either thrombosis or hemorrhage.

Earlier, Mr. Johnson had told me that he had been reporting to the hospital outpatient department from time to time for his blood tests. By the end of the session, he had agreed to review a schedule for blood tests with his doctor before his discharge from the hospital.

After our discussion, Mr. Johnson was able to summarize signs and symptoms of dicumarol overdosage including nose bleeds, bleeding gums, excessive bruising, smoky colored urine, dark stools, etc. He was also

able to state measures to be taken in case of an overdose.

Our teaching session helped to reinforce or review information about precautions to be taken while on anticoagulant therapy. Mr. Johnson had been generally aware of the necessity to avoid trauma; he told me that he had already been shaving with an electric razor rather than a straight razor. But by the end of the session he could also tell me the reason why he should avoid taking ASA or related compounds while he was on dicumarol.

I feel that Mr. Johnson's learning needs were met through reaching the goals we established. He had an opportunity to review his present knowledge as well as to learn new information. His retention of this information was evident when he proceeded to relate what he had learned to his wife later that day. And for myself, I found that by using four problem-solving steps I was able to develop a simple but comprehensive teaching plan, tailor-made for Mr. Johnson. And that gave me a good deal of satisfaction.

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ANECDOTAL RECORDS

Jennifer Craig

Dear colleague:

So you have to write anecdotal notes and you don't have the first clue how to go about it!

- Maybe you're a new head nurse and you are expected to write anecdotes on your staff.
- Maybe you're a new clinical instructor and weekly anecdotes are to be recorded on students.
- You may even be an "old" head nurse and a performance evaluation system has caught up with you.

Whatever your reason for keeping anecdotal records, if you're new to the job, you may pick up some tips from this "How to."

P.S. If you've been writing anecdotes for years, can do it with one hand tied behind your back, then please turn to the next article; this one is not for you.

Just the facts, please

What is an anecdote? Let's begin by defining it as a "description of a specific action." It is a descriptive statement of a *single* incident, unlike a newspaper story which is a description of a series of incidents, interspersed with the reporter's interpretation, and dotted with a few emotionally charged words for good measure.

"OK then," you might say, "when I was at work today I saw Mrs. T. push open the swing door and walk into the ward. So what?"

Yes, that is a descriptive statement of a specific action but in order to be a useful anecdote, it must also have relevance to the situation in which you are working.

"OK then, Mrs. T. is a new L.P.N. on probation and I saw her come into the ward with a coffee tray in her hand. That's relevant to my situation. So what again?"





Yes, but as well as being relevant, a useful anecdote must also be significant; it must contribute either positively or negatively to the accomplishment of the goals of the institution for which you work, or to the goals of the profession in which you practice. So if you found that Mrs. T., on her own initiative, was taking a coffee tray to the relatives of a seriously ill patient, the anecdote would be useful.

Effectively stated anecdotes record only facts. No judgments, opinions or conclusions are noted. (Occasionally the recorder's interpretation is needed to provide clarity or meaning; in this case the interpretation should be kept separate). The basic idea is to write down observations in behavioral terms. So let's digress for a moment to explain what is meant by "behavioral terms." (If you already know, you can skip these paragraphs).

Observable behavior

A behavior is the way an organism responds or acts. Sometimes the response is not observable, such as glandular action, or a thought, or an increase in heart action. Usually though, we use the word "behavior" to indicate an observable action such as shouting, writing, speaking, or walking. It is important to clearly differentiate between what you see or hear (observable behavior) and what you think or infer about a behavior (your judgment). Which of the following statements describe an observable behavior?

- a) Arrives at work on time.
- b) Adapts to new situations.

The answer is (a) of course. You can see someone arriving on the ward and you can see the clock; your opinion is not called for. But how about (b)? Can you see a person being adaptable? No, of course not! From various actions that you see or hear you may *infer* or *judge* the person to be adaptable. The same is true of loyalty, commitment, responsibility, attitude, persistence, dependability etc. — they are all judgments formed on the basis of observable behaviors that we unconsciously register. Eventually it becomes necessary to make these kinds of judgments about the individuals the anecdotes describe. However, the judgment is made on the basis of a *collection* of anecdotes. A judgment should not be included in a single anecdotal statement that describes a specific action.

You are working behind screens and hear a nurse say to a patient, "You have done nothing but complain all day." You think that the nurse is exceptionally rude and unsympathetic.

1. What did you hear?
2. What was your judgment?
3. What other judgments could be made?

What did you hear? You heard a nurse say, "You have done nothing but complain all day." You did *not* hear a nurse being critical, or being bad-tempered or being exceptionally rude and unsympathetic. If you *thought* any of these things, that's fine, but recognize them as judgments — judgments made on the basis of what you heard. Other judgments, equally valid, could be that the patient was "difficult," "complaining," in pain, or that the nurse was overworked, tired, in the wrong job etc.

A behavioral term then, is a description of a behavior that can be seen or heard by another person; anecdotes are recorded in behavioral terms.

An anecdote is a description of a specific action. An effective anecdote is:

- Relevant
 - Significant
 - Factual
 - Written in behavioral terms.
-

Which of the following are effective anecdotal statements?

1. Responded abruptly and discourteously to an inquiry from the daughter of a dying patient.
2. Expressed anger at being asked to work with a student.
3. When caring for a chronically ill patient whose daughter had nursed him at home for seven years, the daughter suggested a deviation in the routine procedure performed by Miss M. Miss M. replied that she had been properly educated and asked the daughter to leave the room.
4. While talking to a crying patient, Miss J. discovered that the patient was a Roman Catholic and without friends or family. Miss J. notified the priest and asked him to visit.
5. Mrs. B. was pleasant and helpful during the emergency.
6. Phoned physiotherapy department for

advice on the transfer of a 250 lb. hemiplegic patient from bed to chair.

Numbers 3, 4, and 6 are effective anecdotes. Remember, we were looking at the effectiveness of the anecdote — not the effectiveness of the behavior it describes.

Now that you can distinguish between an anecdote with quality from one of inferior stock, let us consider why you should want to keep them at all.

Purposes of anecdotal records

The primary purpose of an anecdotal record is to serve as a basis for evaluation. Evaluation means "to judge or determine the worth or quality of." As a head nurse or instructor, you are often required to judge the quality of a worker's performance or of a student's learning and acquisition of skills. These judgments may make you uncomfortable because no one likes to "play God." You may be asked to account for your opinion. You could bluster and say, "Well, after all, I am a Head Nurse and surely my opinion counts for something." Or, you *could* present an anecdotal record and say, "These are objective observations I have made and my judgment is based upon them."

An anecdotal record also serves as an aid to memory. Ideally anecdotes are a series of "verbal snapshots" which, when reviewed by the recorder, allow her to recall incidents objectively. If the incidents are recorded according to the criteria suggested above, they may be reviewed in perspective uninfluenced by the emotions the observer may have been experiencing at the time of the incident.

If you are a head nurse who has to review the performance of one of your staff over a long period of time, such as a year, how far back can you remember incidents involving that staff member? About two weeks if you have an average human memory. A month maybe. Can you justify evaluating a year's performance on the basis of recent weeks? If you are a clinical instructor, anecdotes may help you to remember behaviors that students exhibited at the beginning of their clinical experience. A comparison of these behaviors with current behaviors may help you to assess the amount of learning that has occurred.

With this written memory in front of you another function of anecdotal records becomes apparent. The head nurse can see *patterns* of performance over a period of

time, instead of fragmentary impressions based on recent experience. The clinical instructor can identify learning patterns from week to week. A review of the anecdotal record may reveal difficulties that need to be rectified prior to the student's final examination, or areas requiring additional practice and experience.

The purpose of an anecdotal record is to:

1. Serve as a basis for assessment and judgment.
2. Aid memory
3. Identify patterns of performance or learning.

Biases in recording

One serious limitation in the writing of anecdotes is the difficulty in remaining objective. It is all too easy to notice desirable actions in those we like and undesirable actions in those we don't like. There are three kinds of error which are so common among observers that you should be aware of them and watch for them in your own observations.

The first error is the "halo effect" which occurs when an observer is influenced by general impressions. If general impressions are good, it is easy to pass off the observation of an ineffective behavior as "just one of those things" or as unimportant. If general impressions are poor, the reverse occurs and the person being observed is seen only as inadequate.

Another type of observer error is the "personal response tendency." This varies with the observer. Some observers will only record desirable actions and display the "generosity error." Others will only record undesirable behaviors and display the "severity error." And then there are those who see everyone and every behavior as average. An assessment of these observers' records will reveal no strengths or weaknesses in anyone; everyone functions in the same manner.

A third type of bias is the "logical error." This occurs when observers are influenced by their assumptions that certain things go together. For example, is someone who is slow necessarily methodical? Or is the person

who talks a lot automatically knowledgeable? We were probably conditioned to think like this in the bedtime story era when strangers were tall, dark and handsome and princesses were always beautiful.

It is difficult to ignore our feelings when observing worker or learner behaviors. However, being aware of our own bias is the first step toward becoming an impartial observer.

Biases in recording anecdotes may be:

1. The halo effect
2. The personal response tendency
3. Logical error

Hints on writing anecdotes

Writing anecdotes takes time and the task may be put off as each day rushes by. Nevertheless, anecdotes should be recorded as soon as possible after the incident and before the details have blurred. If your skills include shorthand, well and good, but if not you could develop your own form of shorthand or use abbreviations. Comments that are to be recorded should be described as heard and enclosed in quotation marks. Always note the date. The sequence of dates may be informative later, when you review the entire record.

On what should anecdotes be written? Some people have found a Kardex system a good way. They keep a card for each worker or learner. Others use a recipe box with a section for each person and a separate card for each incident. Whatever system you choose, it is important to remember that an individual's record is confidential and that she/he must know that it is being kept and have access to it. The record is there to serve as a basis for a fair judgment, it is not secret evidence, accumulated as a stock-pile to be used in a "showdown."

The evaluation process

No matter what it is that is being evaluated — a worker's performance, a student's progress or a pair of shoes — the process of evaluation is essentially the same. It takes place in two stages. The first phase consists of gathering information in order to provide a description of the object to be

evaluated. For example, we might examine a pair of shoes and note the color, the style, the type of sole, the height of the heel and the price. This information is noted before we engage in the second phase of evaluation which is judgment. On the basis of the information that has been accumulated, we judge whether to buy the shoes or not.

We are all guilty at times, of entering into phase two of the evaluative process before we have completed phase one. That is, we make hasty judgments based on incomplete information. When evaluating employees or students it is very important to be sure to give phase one the careful attention it deserves. Anecdotal records are a way to help you collect reliable information so that the judgments you make are not based on whim.

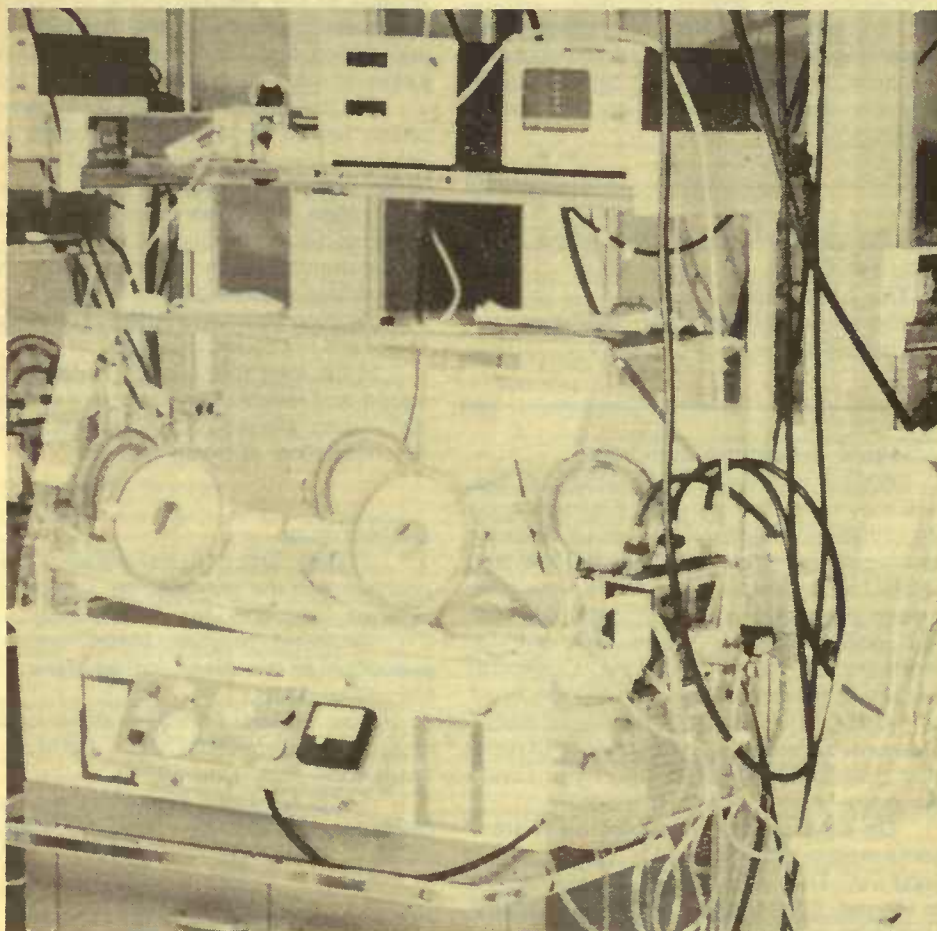
In the long run, it is the ability to make sound and reliable evaluations of the people and events around you, which will earn you the reputation of being "fair." ♣

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Pediatric intensive care involving parents in the care of their child



Susan Schaeffer Jay

The child who is suddenly whisked into the I.C.U. is one of the most vulnerable patients a nurse encounters. The acuteness of his health problem frequently leaves his very life in question. The suddenness of his admission seldom allows time for his preparation. Initially he is very ill, confused and usually without anyone he knows.

His parents are upset and very frightened. Frequently they are overtired and have not eaten for a long period of time. They too are vulnerable! It is in this state that they are expected to answer questions about their child's history that determines the course of his medical treatment. Often parents are asked to give consent for emergency diagnostic procedures or surgery before they have seen their child or understand his condition.

I have observed many parents during the crisis of their child's admission and followed them through the child's short or long term stay in I.C.U. It has been my observation that parents usually respond to this crisis in a predictable pattern. If a nurse understands the dynamics of this behavior pattern she will be able to intervene in the crisis and gradually assist the parents to become involved in planning and participating in their child's care.

Faced with sudden acute illness and the possibility of losing their child, parents are often immobile and unable to reach out to their child at a time when the child's need for them is acute. It is evident that a major role of the I.C.U. nurse is to assist parents to become involved with their child during the crisis of sudden acute illness. I would like to share the methods I have found successful because they seem to be theoretically sound and clinically practical.

This paper has two purposes, the first to increase nurses' awareness that the child's need for his parents is greatly increased while he is in an Intensive Care Unit (I.C.U.) and secondly to demonstrate how to encourage and assist parental involvement with their child in Pediatric Intensive Care Units.

The trauma of hospitalization has long been attributed to fear of painful

procedures and separation from parents.^{1,2,3} Nurses have long supported the rights of children and parents by encouraging rooming-in and extended visiting policies. Yet the struggle has just begun to penetrate the doors of Pediatric I.C.U.'s where signs still say "No Visitors Except Parents," and "Parents May Visit for 5 Minutes Out of Each Hour."

My nursing interventions are based on Rubin's theories of maternal role acquisition⁴ crisis intervention, and maternal touch.⁵ Rubin has identified the process of initial maternal role acquisition.⁴ She is also careful to explain that each time a woman has an additional child she must again go through the entire process of griefwork, role play, mimicry, and projection-introjection which end in the woman's sense of identity as mother to her new child.⁴

A very similar process occurs in parents when their child becomes acutely ill. These parents seem to go through the process of role acquisition. Three behaviors described by Rubin,⁴ are particularly easy to observe. These are griefwork, mimicry, and identity.

Because of the similarities with role acquisition I will refer to the series of parental behaviors as "role-revision." I define "role-revision" as the process of giving up the role of being parent to a well child and taking on the role of parent to an acutely ill child. Both parents seem to go through the process of "role-revision," but usually the mother proceeds at a more rapid pace. The father has more to assimilate because his relationship with his child often changes to more of a caretaking role than he usually assumes.

The description of maternal touch identified by Rubin is a useful indicator of the progress of "role-revision." The first concept is griefwork which is common to most situational and maturational crises. Rubin talks about the new mother grieving for her previous role as she enables herself to take on the new role.⁴ Likewise before they can take on the role of parent to an acutely ill child parents need to grieve for their lost role, parent to a normal child. They need time to resolve the fact that others have their child's life in their hands, that they are no longer in control, and that they may no longer know what is best for their own child.

The first goal is to re-unite the child and his parents as soon as possible. Although parents are very worried when their child is admitted to the I.C.U., they often have a difficult time actually going into the unit. It is essential that trust be established between the parents and the staff. Just as Erik Erikson believes that the child does not move successfully from the first stage (Trust vs. Mistrust) to the second stage (Autonomy vs. Shame and Doubt)⁶ of development without mastering the first, I believe the parents must trust the staff in order to be able to feel secure enough to care for their child in I.C.U.

The initial contact that parents have with the I.C.U. seems to be the most important. It involves 1) meeting the nursing and medical staff immediately responsible for their child, and 2) entering the unit to see their child. These experiences seem to set the tone for

the parents' experience in the intensive care setting. If nursing support is not present to assist parents with both parts of the initial contact the parents have difficulty supporting their child during the entire experience.

Parents are often afraid to see their child. Some parents are afraid of what other children will look like. During the initial contact with the nurse it is very important that the parents be told that their child will need their support and that the nurse will be available to assist them in being supportive to their child.

Parents also need to know that they have rights. Explaining their rights in a supportive, caring manner will go far in establishing a trust relationship between the nurse and the parents. The parents have the following rights:

- to know what is happening at all times with and to their child (they do not have the right to be given any information about other patients)
- to call or visit anytime day or night
- to leave anytime but are asked to inform their child and his nurse when they plan to return.

Parents need to know that the I.C.U. has several rules which they must follow:

- only parents may visit (special permission for others is occasionally granted but with careful planning ahead of the visit)
- parents are expected to leave temporarily when asked. (parents are asked to leave during emergencies, intubation, insertion of cut down catheters, lumbar punctures, etc.)

The parents are likely to be in acute crisis during the nurses' initial meeting with them. This stage of role-revision is griefwork. The parents' ability to hear, understand, and remember may be very limited. Although they need to hear about their rights and the rules of the unit this should not be the only opportunity they have for hearing or reading about them.

Even with careful, slow explanations, the initial experience is often overwhelming for parents. Without an explanation about the I.C.U., the experience can be such an acute crisis that their progression in role-revision is severely delayed or stopped. Parents who initially either do not receive (or hear) a careful explanation tend to be the ones who visit infrequently and for short periods. They seldom call. The following excerpts are from a conversation with parents whose 4-week-old infant was admitted via ambulance. The baby, Amy, had severe pneumonia and bronchiolitis. She had been intubated and placed on a respirator. Her blood gases were poor, her condition unstable. The conversation occurred about five minutes after the parents arrived outside

the unit. (They had not come with the baby in the ambulance).

"Mr. and Mrs. B? (nod yes) I am Susan Jay and I am Amy's nurse. There are several doctors examining Amy now and determining how to help her breathe more easily. One of them will be out to talk with you as soon as possible. When she is finished talking with you I will come back to tell you how Amy is and to bring you in to see her. Please wait in the waiting room. There is coffee in the room across the hall."

When I returned to the parents the conversation was as follows:

Nurse: "Mr. and Mrs. B. I know Dr. S. has explained that Amy is still having difficulty and that she has a special tube through her nose which is attached to a machine which is breathing for her. She was very tired and the machine is giving her a rest. I would like to take you to see Amy in a few minutes." (waiting to see their reaction)

Mrs. B.: "I want to see her, but she'll look so awful — she was so blue ..."

Nurse: Mrs. B. Amy is not as blue as she was, she is sleeping and letting the respirator work for her."

Mr. B. (to his wife): "You go, I'll wait here."

Nurse: "Neither of you have to come in right now. Let's sit down and I'll tell you what it's like in the unit and exactly how Amy looks."

The parents often need to be encouraged and assisted to come into the unit to see their child. They should never be forced or made to feel inadequate if they are not able to face the situation.

How much the parents will be able to interact with their child in I.C.U. depends largely on their first view of their child on an I.C.U. stretcher attached to many machines. Most people are confused if not frightened by mechanical devices which blink, buzz, light up, and alarm. Parents tend to equate the degree of seriousness of their child's illness with the number of machines at his bedside.

Even with careful preparation it is difficult for parents to actually see their child beneath the machinery. Preparation of the parents for exactly what they will see once they step inside the I.C.U. door prior to taking them to see their child affords the nurse and the parents an opportunity to test out the trust in their initial relationship.

I sat with Mr. and Mrs. B. and explained what the room looked like, interspersing information about how Amy looked.

Mrs. B.: "I really want to see her. If she dies I'll be so upset. I would like to go in with you."

Nurse: "That would be fine, would you care to join us Mr. B?"

Mr. B.: "You go ahead (to his wife) I ... just can't."

Mrs. B.: "I know, I'll be back soon."

As Mrs. B. put on a gown, I reviewed the basic ground rules briefly. I walked with Mrs. B. to Amy's bedside. Mrs. B. appeared stunned; she stared at Amy who was positioned on her back, with extremities restrained. Amy was intubated, and on a respirator. There were leads to a cardiac and respiratory monitor. Amy had an intravenous drip and one arterial line, each with their own IVAC machine. Amy lay motionless, except for the rising and falling of her chest. As soon as we stood at the bedside I placed my hand on Amy's head and said to Mrs. B., "She is a lovely baby, I'm sure it is difficult for you to see her like this."

Mrs. B.: "She is so still ... Is she alive?"
Nurse: "Yes, she is. Look at her breathing, her color is better. See up here, this number is her pulse rate. It shows how many times her heart beats each minute."

Mrs. B.: "I see — Yes, she is alive — thank God. I thought she had a cold, I called the doctor, I gave her the other children's medicine — a quarter of a teaspoon, just like he said." (pause) "I knew this morning — her breathing ... no, her color and fast, fast breathing. She was always pale, but never blue ... before today. Do you think if I took her — If I demanded he see her — I mean I didn't demand to bring her in — I just called every day and said she was worse. She could die — oh, she couldn't ... she really could — she was so good and then this. I should have seen it, the color, I'll bet that was it — I should have said she was pale."

I talked with Mrs. B. about Amy's symptoms and tried to reassure her that she had done what she should have by calling the doctor and following his directions. I told her that gradual changes in a baby's condition are always difficult for parents to see because they see the children all the time. I equated it with their growth and reminded her that



parents are not as aware of growth as others who do not see their child every day.

Mrs. B. seemed relieved. She then touched Amy's right foot with her index finger.

Rubin applied her observations of maternal touch progression to student nurses in labor rooms and clinic settings.⁵ Students in Pediatrics go through the exact same process. The more acutely ill the child is the longer it takes for the students to place their palms on the child or pick him up. Parents coming into the intensive care unit are initially hesitant to touch their own children. Although there are some parents who move right into caressing, kissing and holding their child, they are the exception. Rubin further wrote of the new maternal infant relationship:

Until the infant can actively participate and contribute, the relationship may be very tenuous. A one-way relationship is difficult to bear. There is relatively small pleasure in caring for someone whose repertoire of responsiveness consists of taking and consuming, and who otherwise is passively indifferent to all ministrations.⁷

Almost invariably observations of mothers in I.C.U. match Rubin's observations of the new mother:

She moves from very small areas of contact to those more extensive. At first only her fingertips are involved, then her hands (including her palms) and then, much later, her whole arms as an extension of her body.⁵

Most often the parents first touch the child's head, fingers or toes, with the tip of their index finger. Often the infant or child in I.C.U. is non-responsive. Almost invariably they are restrained and have intravenous and cardiac monitor leads. It takes longer for parents to touch their children who are unable to respond to them. Children who are responsive sometime initiate the contact by reaching for their parents.

Is there a value to observing that parents usually repeat the process of touch progression when their child is admitted to the I.C.U.? Anna Freud says that the child's dependence on touch increases when he is ill.⁸ It is not known how much awareness is present in the unconscious child, but there is always the chance that sensation of touch and hearing are present. If parents are going to be involved in their child's care, the first step is getting them re-involved with their child. Parents usually follow my example when I touch their child and talk to the child. I tell parents that their child may be able to hear them and feel their touch even though he cannot respond.

One of the reasons parents are hesitant to touch their child is fear of hurting them — fear that they may do something to disconnect the respirator or make the monitor alarm. Some parents need permission to touch their child, others need to observe nurses handling their child for a long time before they venture to begin the slow touch progression.

Once parents are comfortable touching their child they move into the second phase of parenting their ill child. In this period they become at least minimally involved in the child's care. Early in this period the parents notice other children and search for someone "worse off" than their child. They begin observing how other parents act toward the children.

Rubin⁴ describes the new mother's use of mimicry in caretaking. Parents in I.C.U. mimic the responses of the other parents and eventually some of the caretaking of the nurse. The parents observe the nursing task and appear to sort in their minds which are similar to what they do with the child. At this point the nurse needs to be alert to parental comments such as: "It is too bad you have to tie that hand down. She likes to suck that thumb." or "She always goes to sleep with her music box."

Parents can be reassured that every effort will be made to make the baby's thumb available to her. Explanation should be given about why the hand is restrained. They should be asked to bring the music box for the child. Parents want what is best for the child. They appreciate and usually accept any reasons that they can understand.

Once parents give cues such as: "I usually do it this way at home," they have reached the third stage: Identity.⁴ By this point they have done much of their griefwork, progressed through a period of mimicry and are ready to slowly take on their revised identity, parent of a sick child. They are ready to proceed from simple to complex functions in their child's caretaking. However, what is simple for one child and parent may be complex for another. It is easier to change the diaper of the child who has had heart surgery than a child who has had a colostomy. When assessing parents' ability to participate I try to find something that they do at home such as diapering, washing the child or turning him. I usually say: "I am going to bathe Johnny now, would you like to stay and watch?" If they say yes, I prepare for the sponge bath and if the child is intubated I wash his face, chest, and arms and then say, "I need to wash his back, would you like to help me turn him?" If one of them agrees I ask them to hold him or bathe his back — whichever is simpler in their child's situation.

Parents can be taught to do such procedures as tracheal suction, but this is only appropriate for a child who is going home with a tracheostomy. One mother whose child has a congenital absence of many of his chest and abdominal muscles participates in all of his care except monitoring vital signs. Her child has been a frequent patient in our I.C.U. and she does all of the same procedures at home. When he is extubated she is better able to do tracheal suction than the nurses. She has learned how to position him so precisely that she seldom misses the trachea.

An example of the benefits of having mothers and fathers participate in their child's care in the I.C.U. is Michael, who was born in a suburban hospital and rushed to the medical center. He was in the operating suite at the age of 1 1/2 hours. He had a very large diaphragmatic hernia, too large to repair normally. A patch was sewn in. Michael returned to the unit post-operatively and due to many complications (rejection of patch, repeated infections, inability to breathe substantially without the aid of the respirator) Michael remained in the I.C.U. for one year. It was a difficult year — we never knew if Michael would survive. We could not see how he could, yet we felt his own determination and the dedication of his parents. We joked about requesting the respirator manufacturers to design a back pack respirator which would run on batteries so Michael could go home.

During the many weeks of uncertainty, Michael's mother came every morning, she gradually began to touch him, to talk to him and then to hold him (respirator tubing and



Photos by Children's Hospital of Eastern Ontario.

all). He had his rough moments: mucous plugs, cyanotic episodes, infections and many more. We all learned to cope with them. His mother became frightened many times when Michael had a cyanotic spell while on her lap and had to be whisked into bed and suctioned. She was able to talk about her concerns and her hopes. She stayed each day until dinner time when Michael's dad would come in to visit. He would usually hold Michael awhile and then the parents would go home together. It was a long, hard year, but despite his setbacks, Michael learned to smile, sit and play like other babies. He may be the only child who learned to jump in a jump chair and ride in a swing while on a respirator. Michael's corner of the unit reflected his developmental level. His I.C.U. stretcher had a busy box, a favorite doll his mom had made and lots of other toys. His parents brought his baby clothes and gradually exchanged them for toddler clothes as he grew. He was cared for by many nurses, but one particular nurse was almost always assigned to him. He had as much continuity in care as possible for a child in I.C.U. He became familiar with all of the people in I.C.U. and he eyed strangers cautiously.

After Michael was in the unit a year he had grown enough to have further surgery.

He recovered remarkably fast, no longer needed his respirator and went home for the first time when he was just over one year old. He is now a normal, alert, two-year-old. His normalcy in development could never have been achieved without consistent interaction with his parents. He also had excellent nursing care and an important goal of that nursing care was to provide every opportunity for the relationship between Michael and his parents to develop normally. Watching them grow together as a family was a very rewarding experience.

Children such as Michael are not common inhabitants of the I.C.U. Most children are acutely ill for a short time. Many parents never achieve the degree of parenting in I.C.U. as that of Michael's parents. One factor perhaps in their favor was that they did not have to revise their role — it emerged in I.C.U. They still had to go through the steps to attain their roles, the setting was unexpected, but they grieved, became comfortable and then participated in the care of their child.

It may be unrealistic to expect parents whose children are only in I.C.U. briefly to work through the three stages of role-revision, but the nurse who takes the time to encourage the parents to participate even slightly in their child's care will have a less vulnerable patient and a family who cope with their crisis in a healthier manner.

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A Coronary Care Unit implements primary nursing

Marlene Medaglia

The Coronary Care Unit (CCU) at the Montreal General Hospital consists of a six-bed acute care monitoring area and a three-bed stepdown or subacute care area (SCU). The unit is staffed with a head nurse, twelve full-time registered nurses, three part-time registered nurses who work only the evening shift and a unit manager who is shared with two other units.

Two years ago, our CCU was relatively free of major problems. We believed that the patients received good nursing care, the staff worked well together and there seemed to be good communication between the patient, his family and the nurse. On the whole, one could say that the staff enjoyed their work and that the patients seemed satisfied with the services they received.

As the head nurse on the unit however, I am continually trying to find methods of improving the nursing care we give our patients. Even though our unit was without major problems at that time, I think that it is healthy and therapeutic to look towards change for improvement of a situation, no matter how good that situation seems to be.

The way we were

In evaluating how the unit functioned on a day-to-day basis, I found many areas where improvement or change was warranted. One very important question I kept asking was: Is the coronary care nurse given the opportunity to meet the full challenge of her role? It seemed to me that this was not always the case. Perhaps by reorganizing our daily activities we might be able to acquire more valuable time for patient care and staff development.

Our staffing pattern allowed for three registered nurses plus the head nurse or nurse-in-charge on days; three RN's on evenings and two RN's on nights to give direct nursing care to nine patients.

In looking at how the unit functioned, it was observed that:



Primary nurse and head nurse, Marlene Medaglia, with her patient during a teaching session.

- there was a tendency for nursing care to be task-oriented. Energies were directed more to the physical needs of patients, to the carrying out of medical orders and to the completion of tasks e.g. taking electrocardiograms.
- the head nurse seemed to accept the sole responsibility for care planning and the follow-through of such planning. This resulted in nursing care plans that were fragmented and incomplete.
- nurses who could organize their work and do it efficiently usually accomplished the most during the work day.
- little patient education was provided. Patient teaching tended to be left to those nurses who felt comfortable and who enjoyed doing it.
- patients, themselves, often felt reluctant to ask for the help or information they needed. Often, they could not remember who their nurse was and didn't want to bother the wrong person for information.

- the head nurse or the nurse-in-charge gave out the medication, transcribed the medical orders, made arrangements for special tests or activities to be done and also acted as an intermediary between the patient, the patient's family, the medical staff and other health team members. This tended to discourage the other coronary care nurses from assuming total responsibility for patient care; it created an environment that was not conducive to their full participation in decision making in the CCU.

Analysis of these observations led us to conclude that comprehensive nursing care was not being provided in CCU and that the nursing care that was being given was inconsistent. The task now was to find a way to improve this situation.

The solution

It was at this point that I thought of primary nursing. Primary nursing, with its emphasis on the concept of "my nurse" and "my patient," is based on five principles:¹

1. 24-hour decision-making for several patients by one nurse;
2. nursing assignments based on matching patient needs and nursing skills;
3. nursing care planner is the care-giver;
4. direct care-giver to care-giver communication;

5. head nurse in a crucial role as leader, clinician, consultant, evaluator, staff developer and teacher.

Having one nurse assume responsibility for the total care of a patient(s) until his transfer from the unit would, we hoped, result in more comprehensive nursing care for our patients. This nurse, called the primary nurse, would provide direct care to her patient(s) each day she was on duty. By taking a special interest in one or two specific patients, the nurse would be better able to identify her patient's total needs — biological, psychological and social. Unlike total nursing care where the nurse's responsibility for her patient ends when she finishes her shift, the primary nurse would be responsible for planning her patient's care for his entire stay in CCU. Her plan of care would be carried out by an associate nurse when the primary nurse was not on duty.

To ensure that her plans for meeting her patient's needs are carried out and that consistency of care is maintained from shift to shift, it is necessary for the primary nurse to develop a comprehensive nursing care plan for each one of her patients. This written plan facilitates the involvement of other staff members in the care of the patient.

A one-to-one nurse-patient relationship would allow the primary nurse to care for her patient(s) in her own way; it would allow for individualized care for each patient. This continuity of nurse-patient contact would encourage a relationship of trust, warmth and confidence and would allow for the establishment of understanding between the nurse, the patient and his family. This rapport would be conducive to patient teaching and facilitate his integration into his home environment.

Implementing the solution

The decision to try primary nursing was discussed with all the coronary care nurses on our unit. We decided to hold regular meetings at a time when staff from two shifts might attend. The purpose of these meetings was to determine how to gather information about primary nursing, how to adapt it to our needs and how to implement it in our setting. Minutes and attendance at the meetings were taken and put into a binder so that nurses who were unable to attend could keep up-to-date.

As a result of our meetings:

- the head nurse obtained a bibliography of articles on primary nursing from the hospital's nursing library.
- one staff nurse volunteered to read these articles and to write detailed notes on the subject. Relevant information was then photocopied for each staff member.

- patient behavioral outcomes for cardiac teaching were to be developed so that all staff members would have common objectives. (See box)
- it was decided that only patients with uncomplicated myocardial infarctions would have a primary nurse.
- one main focus of our care would be cardiac teaching, including preparation of the patient and family for his return home.
- since a patient's stay in CCU is of short

could actively participate in his care and have written material for future reference.

Armed with reference material on primary nursing and some valuable working tools, the CCU staff decided to implement primary nursing on a trial basis. At the end of one year, we would evaluate its effectiveness and decide at that time whether or not to continue.

PATIENT BEHAVIORAL OUTCOMES — CARDIAC TEACHING

1. Patient states "I have had a heart attack."
2. Describes what a heart attack is.
3. States the risk factors of heart disease.
4. States which risk factors he can control and how.
5. States the reasons (signs and symptoms) which necessitate his notifying the health team while in hospital or returning to hospital once he is discharged.
6. Describes the relationship between the *ambulation protocol* and the healing of his heart.
7. Voluntarily stays within *ambulation protocol*.
8. Describes plans for activity until his first follow-up appointment.
9. Verbalizes fears and concerns regarding the effects of his illness on his lifestyle.
10. States the name, dose, frequency, function and side effects of all medications he will be taking at home.
11. States why he is on a modified diet.
12. Describes the diet he will be on at home.
13. States when, where and with whom he has a follow-up appointment.
14. States he will not go back to work or drive prior to his first return appointment.
15. Discusses "*Instructions on discharge from the hospital*" with the nurse and has his own copy to take home.

duration, it is impossible to provide all the necessary patient education required. Therefore, the primary nurse would make follow-up visits to the medical units to continue cardiac teaching.

- each primary nurse would choose and plan the care for her own patient.
- the head nurse would also function as a primary nurse, and have her own patient load.
- primary nursing would not be made compulsory. Each nurse could decide whether or not she would participate.

When we began primary nursing we were fortunate in having various working tools already in use. These included:

- an *admission nursing history form* which listed necessary data about our patients.
- a *problem sheet* which was on the front of the chart where active and inactive problems of the patient could be identified.
- a *nursing care plan* in Kardex form where nursing concerns and approaches to these concerns could be written.
- a *cardiac rehabilitation teaching Kardex* which was kept with the nursing care plan. This allowed for documentation of all cardiac teaching that was done.
- an *ambulation protocol instruction sheet*, *drug information sheets*, *discharge instruction sheets* and *pamphlets* from the Quebec Heart Foundation. Each patient would receive this information so that he

One year later

Over the trial period, we found that primary nursing significantly affected patient care in many positive ways.

For example, our observations indicated that the continuity of patient care was promoted. Staff nurses became more involved with their patients thus enhancing the nurse-patient relationship. On his part, the patient seemed better able to communicate his concerns to one nurse; he felt free to ask questions and request information because he knew that the primary nurse had taken a special interest in him and that she was "his" nurse.

As well the coronary care nurses provided better health teaching. Not only was the nurse able to plan the teaching around her patient's unique needs, but she was also able to evaluate how much and how well her patient was retaining this information and when reinforcement was necessary. In addition, she could plan these teaching sessions over a two to three-week time span rather than trying to condense everything into a CCU stay of two-to-five days.

Nurses found that they could function as primary nurses for one or two patients at a

time. They also found it helpful for the head nurse to act as a primary nurse; the head nurse was then able to appreciate the frustrations experienced by her staff.

Nurses on the unit expressed greater personal and professional satisfaction. It was rewarding for the primary nurse to see her goals achieved in caring for patients. Patients were no longer "one-day assignments." Because the nurse could spend more time with her specific patient she was better able to assess and meet his needs. She also had the opportunity to see how he was progressing after transfer to a medical floor; she had the satisfaction of knowing that her patient had been discharged home with the information he required for his convalescence and for his eventual return to a normal life.

Many other important factors contribute to the success of primary nursing in our unit. Adequate staff was available to make primary nursing possible and the unit had the right kind of atmosphere — one that was conducive to change.

There were some negative results as well. It was noted that associate nurses (nurses other than primary nurses) tended to have little contact with patients who had a primary nurse. At times, some primary nurses became overly possessive of their patients and some patients became overly dependent on the primary nurses. This situation was especially noticeable when the patient was transferred to another area. Time was another factor. Depending on the activities occurring in the CCU it was not always possible for the primary nurse to make the number of follow-up visits needed to patients on medical units.

Overall however, the negative results were insignificant to the general improvement in care given to patients over the trial period.

The future

Already we are considering ways of improving primary nursing in our unit.

For example, to enable us to evaluate the effectiveness of our cardiac teaching, a test could be developed and given to patients before and after the teaching program. As an assessment tool, it would test their knowledge level as well as serve as a guide in determining whether or not patients are effectively meeting the expected patient behavioral outcomes.

Personal contact between the primary nurse and the patient would be of great value in determining his progress at home. Telephone contact with the patient at home and/or visiting him during his first follow-up clinic visits are two possibilities.

During the trial period we found that the primary nurse in CCU was not always able to visit her patient as often as she would



Some of the nurses in CCU at Montreal General Hospital: L to R: Michele Hillier, Janet Ang, Cloan Harris, Marlene Medaglia.

like once he had been transferred to another nursing unit. Perhaps at this phase of his hospitalization, nurses on the medical units who are interested in cardiac patients and cardiac teaching could take over as primary nurses using the CCU nurse as a consultant.

Primary nursing provides a good opportunity for nurses to share ideas about the care of a particular patient. Informal unit conferences where nurses can discuss their patients could be implemented. Perhaps such conferences could span the gap between the primary nurse and the associate nurse.

Summary

Primary nursing was introduced into our coronary care unit on a trial basis to provide comprehensive and consistent nursing care to patients and to allow the coronary care nurse to meet the full challenge of this role. I feel that all of these objectives have been accomplished.

With total responsibility for planning and giving care to specific patients, the nurses have shown improved organizational abilities and they are now more confident in their own decision-making abilities. Patients and their families have expressed their confidence in the primary nurse and have often remarked on the excellent care rendered by these nurses and the kindness shown to them. Nursing care plans and charting have become more complete and meaningful. The medical staff have commented many times on the thoroughness of the charting since the implementation of primary nursing. This is quite a change from previously when nursing notes were seldom read by doctors.

After our one year trial, we have decided to continue primary nursing on our unit. It has proven to be an effective method of providing consistent, comprehensive and individualized care to patients — and isn't that what nursing is all about?

Acknowledgement: I wish to thank nursing director, Katherine Randall at the Montreal General Hospital for her valuable advice and guidance given during the implementation of primary nursing in the CCU. Also, special thanks go to those staff members who acted as primary nurses throughout the year. The positive results of their efforts convinced me that primary nursing should continue in our unit.

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Postpartal Assessment

Primary nursing with its emphasis on "my nurse and my patient" is alive and well at the Dr. Everett Chalmers Hospital in Fredericton, New Brunswick. The primary nurses who work on that hospital's maternity unit have found that an orderly assessment of a new mother can provide them with the opportunity for good patient teaching — a function that is an integral part of good nursing care.

Gail Storr

"You'll never catch me working on a postpartum unit ... I couldn't stand that dull boring routine for long!" These words which I carelessly spoke as a student nurse come back to haunt me occasionally now that I work full-time on a maternity unit. In the light of the excitement and challenge I feel each day in caring for new mothers, I wonder now how I could have said, much less meant those words.

Many things have been responsible for the change in my attitude, among them a family-centered philosophy brought about by an increased awareness of the psychology of the puerperium,¹ a new found knowledge of maternal-infant bonding and a growing understanding of consumer rights and the women's liberation movement as it relates to maternity nursing. The real key to the

change however, came from the realization that through purposeful utilization of the nursing process I could provide more skilled nursing care for the postpartum patient — a patient undergoing tremendous bodily changes at a rate never before equalled in her life. I also realized that as a maternity nurse I was in a unique position to provide health information to women at a time when they were keenly aware of their bodies.

As the cornerstone of the nursing process, the assessment phase is only the beginning of good patient care. It provides a basis for planning, implementing and evaluating nursing care as well as helping to answer that intriguing question "Just what is it that makes each mother-baby couple so unique?"

But what should be included in a thorough assessment of a new mother? In consultation with many other nurses and with

growing experience in the field of maternity nursing, I was able to help devise a guideline for nursing assessment of the postpartal patient. The nursing staff at Chalmers felt that an orderly assessment would provide data about existing and potential problems and also would assure the staff of many opportunities to teach a mother to care for herself and her baby.

Prior to instituting the assessment guideline, numerous staff conferences were held on such topics as psychology and physiology of pregnancy and the puerperium, physiology of lactation and the nurse's role in breast feeding, maternal-infant bonding etc. As well, each staff member was given an individual demonstration of the expected assessment performance.



Assessment of the mother

Before beginning the assessment be sure the mother has emptied her bladder and that she is lying on a flat bed. Drape the patient with a flannel blanket, explain each step of the assessment to her and keep her informed of your findings.

1

Breasts

Remove bra and gently palpate each breast. Note shape and appearance:

- Are breasts full, firm, tender, shiny?
- Are there distended veins present and is the skin warm?
- Does the patient complain of sore nipples?
- Are her breasts so engorged that she requires an analgesic, a breast binder or an ice pack?
- Are the nipples flat, everted, inverted, cracked or reddened?

If you notice nodules in the breasts of a nursing mother, they may be an indication that the ducts were not completely emptied at the last feeding. This provides you with an opportunity to teach manual expression.

Many such teaching opportunities will arise during the five or six-day period of caring for the postpartum patient. You should take full advantage of these times to demonstrate breast self examination, to explain breast care for the nursing mother (i.e. cleansing, air drying, breaking suction etc.) and to discuss the other physiological changes that occur such as milk production and the let-down reflex. Take time also to answer any questions the mother may have about breast feeding.

2

Uterus

Gently feel the uterus. Note consistency, descent and location of fundus.

- Is the fundus firm, spongy or boggy?
- Is it above or below umbilicus?
- Is it midline or deflected?

Encourage the patient to feel her uterus as you explain the involution process. The uterus should decrease approximately one fingerbreadth below the umbilicus each day. If the uterus is not involuting properly, think of infection, fibroids and lack of tone.

While checking the height of the fundus, inspect and palpate the bladder simultaneously. If the bladder is full, the uterus may be displaced. In this case a pouch can be observed over the bladder area and you will feel resistance upon

palpation. If voidings are frequent and small, with or without pain and burning, this may indicate infection or urinary retention with overflow. Or the mother may be experiencing "night sweats," frequency and voiding in large amounts. If so, explain the diuresing process and reassure her that a return to normal can be expected, usually within a week to ten days.

3

Lochia

Drape the mother in diamond drape fashion. Assess the amount and type of lochia on the pad in relation to the time the vaginal pad was last changed and to the number of days postpartum: first two to three days — lochia rubra (reddish and thin); next four to five days — lochia serosa (pinkish and thicker); after ten days — lochia alba (white or yellowish white). Notify the physician if the lochia is abnormal in color or quantity, has an unusual odor or contains large clots.

Take the time to inform the mother about the natural changes in the lochia. Explain that she can expect the flow to cease in approximately three to six weeks and tell her when her next menstrual period will begin. Reappearance of menses in a non-nursing mother is usually within six to eight weeks; in a nursing mother, it may be delayed much longer, perhaps even for the entire time she is nursing. This may also be a good time to discuss the resumption of sexual relations, her plans for birth control, and family planning. She should know that she may still ovulate even though she is not menstruating.

4

Perineum

To ensure good visibility provide an adequate light source and observe the perineum with the patient in the dorsal recumbent position and the Simms lateral position.

Check for presence and type of episiotomy.

- Is the episiotomy midline or mediolateral?
- Are the sutures interrupted or subcutaneous?
- Is the suture line intact?
- What is the state of the perineal repair — is there any evidence of inflammation, infection or suture sloughing?

- Is the surrounding skin extremely hard and sensitive or warm to touch?
- Does the patient complain of exaggerated discomfort for expected state of repair?

- Is there bruising and edema of surrounding tissue?

If any abnormalities occur notify the physician. Check the mother's rectal area. Note presence of any change in the appearance of hemorrhoids.

Instruct the mother in performing the Kegel exercise to strengthen her pubococcygeal muscles and to enhance perineal wound healing. This exercise may be done standing, sitting or lying down. Tell the mother to push as if voiding and then to contract muscles as if to stop the flow of urine; hold for the count of five and then repeat. The mother should be encouraged to practice this exercise at least five to ten times daily for the rest of her life. (Mothers who have attended prenatal classes may be familiar with this exercise as the perineal grip or elevator exercise).

As you are making your assessment, discuss perineal care with the patient. Instruct her to cleanse from the pubis to the anal area to prevent contamination of the vagina and urethra with fecal material, and to use sterile pads. The pads should be positioned from front to back. Encourage her to wash her hands before and after changing the perineal pad and to wrap the soiled pads and place them in a covered container. Also, show her where to store the equipment and encourage early self perineal care. You should continue to observe the mother during early hospitalization for good hygienic practices during perineal care.

5

Bowel Function

Question the mother daily about her bowel movements. Mild laxatives or stool softeners may be given to encourage the first bowel movement. Extra fluids and fruits and vegetables will also help.

6

Homan's Sign

Inspect both legs for signs of thrombosis — pain, warmth, tenderness and swollen reddened veins that feel hard or solid to touch. There may or may not be a positive Homan's sign (dorsiflexion of the foot causes calf muscles to compress tibial veins which

may produce pain if thrombosis is present). Any indication of thrombophlebitis should be reported to the physician.

Explain the purpose of checking circulation in both legs to the mother.

7

Diastasis of the recti abdominis muscles

Following delivery, the mother's abdominal muscles feel flabby and soft. This is the result of stretching of the abdominal wall during pregnancy and is also frequently due to a marked separation or diastasis of the recti abdominis muscles. (See Figure 1) At the site of separation, the abdominal wall consists merely of peritoneum, thinned out fascia and skin. Directing the mother's attention to these conditions by enabling her to feel the muscles and the extent of the diastasis may motivate her to faithfully perform postpartal exercises.

Briefly explain the location and anatomy of the rectus and oblique muscles and the separation that occurs with pregnancy. To illustrate to the patient the extent of the diastasis, have her lie flat on the bed with legs together. Ask her to point her toes to the ceiling and lift her head so that her chin rests on her chest. Let her feel the extent of the diastasis or separation. Then discuss specific exercises that will assist her return to her pre-pregnant state.

8

Emotional status or affect

Throughout the actual physical assessment and during the rest of her hospitalization, take note of the mother's emotional state. Talk with her about her feelings toward labor, her conduct during labor, feelings about the baby and her perceptions of how the lives of herself, her husband and other children (if any) will change. Explain that she may experience emotional highs and lows and that this lability of her emotions is probably due to hormone changes as well as to the sense of responsibility she may feel at becoming a mother.

Note whether the mother exhibits dependent behavior characteristic of the "taking-in" phase or whether she is beginning to make the transition to independent behavior characteristic of the "taking-hold" phase of the puerperium. Information about all aspects of these phases² enables the nurse to judge their impact on the patient and to formulate appropriate nursing actions. The nurse should also assess the state of maternal-infant attachment or the bonding process. How does the mother react to and handle her baby? Are there verbal or non-verbal cues which may be important?

Assess the mother's desire for extended contact with her baby and her learning needs about infant care. Provide the opportunity (if so desired) for the mother to practice infant care skills and to discuss normal infant growth and development.

Conclusion

Over the past year the nursing staff at the Dr. Everett Chalmers Hospital has found that the guideline enables them to provide individualized, personal care. Patient and nursing administration response to the program has been tremendous and the positive feedback received has encouraged all nurses to more actively utilize the nursing process.

Maternity nursing dull, boring, routine — Not by a long shot!!!

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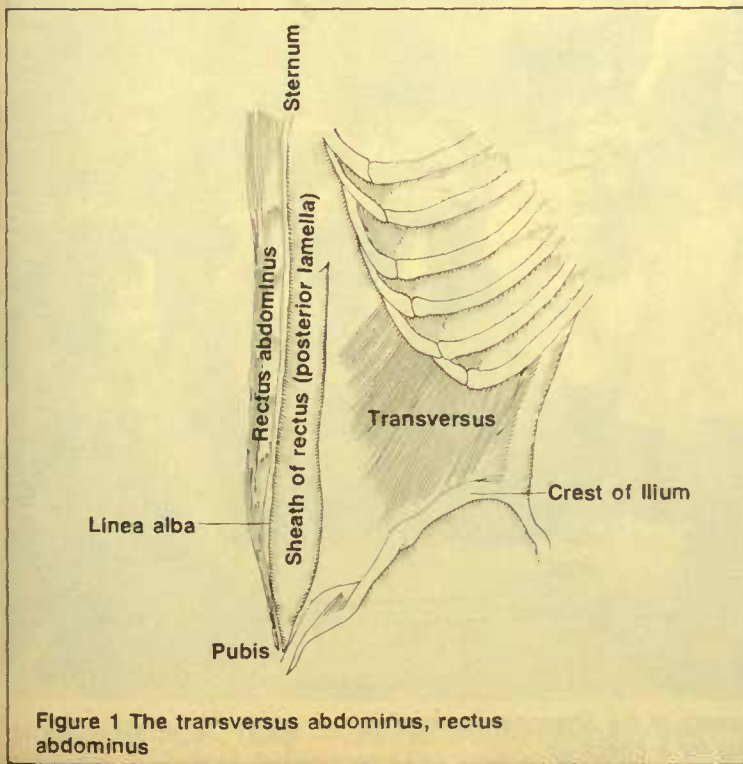


Figure 1 The transversus abdominis, rectus abdominis

CHANGING ROLES IN A CHANGING LAND

The following observations are based on a 19-day visit I made to the People's Republic of China last summer. There were 18 people in our group, representing a variety of backgrounds and occupations. As a nurse, my own focus during our brief visits to clinics and hospitals was on the role of the nurse within the Chinese system of health care.



MORNING CHECK-UP — At the nursery of the Shanghai Workers' Hostel, children line up each morning for a check-up.

Barbara Devine

Because China is still a poor country, it is difficult to understand its progress except in relation to its past. Before the revolution, poverty and ignorance were reflected throughout the country. Social ills such as venereal disease and drug addiction ravaged the people. Worm infestation, death associated with childbirth, tuberculosis and schistosomiasis were common throughout the country. After the revolution, health campaigns intended to mobilize the people increased health services to China's peasant millions. Venereal disease and drug addiction have been virtually eliminated. New health policies have been implemented to make China a nation of healthy, productive people.

In spite of these advances, it would be misleading to paint a picture of China which portrays the health care system in that country as utopian. China is still a poor nation. Disparities continue to exist between health care services in the city and those in the country. Equipment is often old and outmoded. In another sense, however, Chinese medicine impressed me as being rich indeed. These are some of my impressions:

• On Politics

It is not possible to separate medical care in China from the socio-political system of that country. The ideas of Mao-Tse-Tung and the

memory of Norman Bethune's spirit are a driving force behind the delivery of health care services. Politics are so much a part of the thought processes of the Chinese that most behavior is a consequence of political influence guiding their actions. Moreover, this political outlook is of a specific kind and very different from the outlook that we are accustomed to. In the Chinese medical arena a great deal of emphasis is placed on diminishing elitism, mysticism, dominance of one group of medical workers over another, and superior attitudes in relationships among workers and patients.

Westerners are startled at how often slogans such as "serve the people," "use the past to serve the present," and "self-reliance" are used. Nor do these appear to be empty phrases, but rather a revolutionary way of thinking that welds health care workers into responsible members of a health team.

• On status

The main problem I had when we visited a hospital or clinic was that of sorting out the professional status of the various health care workers we met. Accustomed as we are in our society to labeling and responding to specific role status, I found it difficult sometimes to understand the role and functions of many of the medical workers we came in contact with. Many of the doctors originally had been ▷



MOBILE MEDICAL TEAM — Children of Tung nationality welcome members of a mobile medical team of a Chinese People's

RETURNING FROM THE HARVEST — Barefoot doctors and peasants of Kansu Province in northwest mountain district on their way home from collecting medicinal herbs.



nurses. Some nurses were studying to become doctors. Did that make them medical students? Not necessarily, we were told. In some cases they would achieve a certain level of education and not proceed any further. Some medical workers, (or "barefoot doctors" as they are sometimes called in the countryside) were studying to become doctors. Others were studying to increase services to the area in which they were living or working rather than to become "professional doctors."

- **On doctors and nurses**

In Canada I have observed that, if there are tasks that can be performed by either a doctor or a nurse, the nurse will carry them out only when loss of the performance of these functions does not constitute a threat to the physician's vested interests. For example, in a teaching hospital in Canada, the training of medical students assumes priority; nurses perform technical skills only when that performance does not jeopardize the medical student's learning.

The Norman Bethune International Peace Hospital in Shih-chia-Chuang is both a teaching and research center. When we visited it, I asked the medical director whether the various health care workers at the hospital could undertake similar tasks and, if so, how they decided who would do what. The doctor to whom I addressed my question was a member of the People's Liberation Army, a doctor of internal medicine and the director of the hospital. Her reply was: "We are all comrades and we are all equal. Our aim is to serve the people."

A similar observation was made by an English surgeon who spent many years in China. He wrote: "There is much more equality between doctors and nurses in China than in the West. Medical students and doctors both participate in nursing work under the supervision of trained nurses. Nurses join the doctors in ward rounds and work with them in teams in which there is a division of responsibility. There is not much difference in the salary scale as between doctors and nurses and the type of accommodation provided is exactly the same. The boundaries between their respective spheres of work are much less sharply drawn than in the West and are progressively being broken down. Chinese nurses regularly carry out procedures such as intravenous injections which are usually done by doctors in the West. More and more nurses are learning to administer anesthetics and the operating-room nurses usually assist at operations."

- **On Dr. Bethune**

The memory of Dr. Norman Bethune, a Canadian doctor who travelled to China in the late 1930's and later sacrificed his life assisting the Chinese wounded during their war against Japan, is still very much alive in China today. When we toured the museum adjacent to the Norman Bethune hospital, we could not help but be impressed by the tribute being paid to a fellow Canadian by one-quarter of the world's >



DRYING HERBS — Staff members of Wenhsien County Medicinal Herb Company in Kansu province hang harvest of tangshen in the sun to dry. More than 140 varieties of medicinal herbs are produced in the northwest China mountain district.



PICTURE OF HEALTH — *Children attending the nursery of the Shanghai Workers' Hostel receive regular physical examinations.*



TOURING MEDICAL WORKERS — *Eleven-year-old Uighur girl (left) dances for the touring medical workers who operated on her deformed feet four years ago during a visit to her home in the Chinese countryside.*

population. His diary with its message of fairness, equality and responsibility toward the sick, poor and oppressed remains a continual source of inspiration to health teams the world over.

• On equality

Although our visits to clinics and hospitals were brief we were impressed with the democratic spirit that prevails within the system. Doctors, nurses, orderlies, pharmacists, maintenance workers all work together to provide better services to the patients. Workers at all levels form teams to make their own herbs, produce and raise animals, and work in the fields or orchards. Professionals cannot confine themselves to academic or scientific work but must do physical labor so as not to separate themselves from the people. The idea of doctors and nurses working (albeit a smaller portion of their time than "non-professionals") in the fields or orchards is a difficult concept for Canadian professionals to understand.

Ivan Illich writing on the expropriation of health in industrialized societies has said: "In part at least, the health of a population depends on the way in which political actions condition the milieu and create those circumstances that favor self-reliance, autonomy, and dignity for all, particularly the weaker." In China, patients often play an active part in ward affairs. They select representatives from their wards to guide them not only in studying political thought but in giving suggestions to nurses, doctors and orderlies. A great deal of emphasis is placed on self-reliance at all levels of health care. Not only are the professionals expected to help ease the burdens of the people by helping in the fields but the patients are expected to provide input into their own care, cure and progress towards independence. In effect, patients are also health care workers since they are expected to make decisions about their treatment such as, for example, deciding

what kind of medical treatment they want — traditional or Western.

As a nurse, I was curious about where nurses fit into this scheme. Like their counterparts in Canada who graduate from diploma programs, they spend two years learning to be a nurse. During this period, they spend half of each day on the ward and the other half studying theory and political education. But there the similarity ends.

In our society the medical hierarchy is structured in such a way that the privileged position of the medical profession is protected from encroachment so that it can remain dominant. In China since the aim is to combat rivalry and careerism, doctors do not have a monopoly on medicine. As a result relationships among health care workers are less influenced by a stratification system which can only lead to loss of initiative and to protection of vested interests.

China is still a developing country. What I saw during my visit convinced me, however, that it is a country which will continue to build on a foundation based on equality and mutual respect within the health care field. For me, the evidence was everywhere — in the physical vitality of the people, the public concern for health and the warm relationships of all the members of the health care team in this vast and exciting country. ♡



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WOMEN AT WORK — The deputy head of a People's Liberation Army hospital passes on her experience to a young orderly.



When the Difficult Coronary Patient Is Your Husband

Ruth Wire

I heard Warren scream my name from behind the doors of the ICU unit. "Ruth!" As his wife, as a nurse, instinct demanded that I run to his side. But now I was just a relative, confined to the waiting room and forced to listen to the familiar sounds of the unit where I'd worked up until six months ago.

What was happening in there? By peeking around the corner to the desk, I'd seen his monitor. He was in paroxysmal atrial tachycardia at a rate of about 180. I heard feet running. The emergency cart's wheels squeaked. I heard the defibrillator click. Oh my God! Not that. Was he now in a fatal arrhythmia? I began to knead my Kleenex nervously. I heard the low murmur of the doctors' voices. Suddenly, I heard glass shatter. Somebody had dropped something. I remembered myself during a code. Trying to be efficient, trying to be fast. I could have been the one who dropped that vial or syringe. Did it contain the soda bicarb which would save Warren's life?

They knew I was in the waiting room. Did I make them nervous because I'd worked with them, and knew the unit? Warren's nurse on the evening shift had looked shaken when she greeted me half an hour ago. "You'd better not go in there yet, Ruth," she'd said.

"Just tell him I'm here," I'd answered, determined to be a good relative, and let the nurses do their work.

A day and a half ago, when 55-year-old Warren was admitted with a myocardial infarction, I'd asked to help care for him, reasoning that this would reassure him and help the other nurses. My request had been granted. Now I was not so sure this had been the best plan. I'd specialed him for two and a half shifts before the day nurse coming on took one look at me and said, "You'd better rest, or you're going to freak out!" I realized she was right, thanked her, and went home to sleep.

I'd wakened refreshed, but worried. Something was wrong. I hurried back to the hospital, and there it was on the monitor — PAT. The doctor had said that Warren's infarction was an inferior anterior septal. What if the infarcted place should blow? I heard the defibrillator click again. Then I heard another agonized screech. Were they zapping him while he was still awake? Again, the defibrillator, and his shriek.

I began to sob. Why didn't they give him some IV valium? It was inhuman to throw volts through an alert patient.

Suddenly, the door opened, and the frightened face of the evening nurse appeared. "Ruth, will you come in?"

I saw a familiar scene. All the CCU furniture was clustered about the bed — the defibrillator, the emergency cart, the monitor. Warren was still in PAT. Two doctors flanked the bed and were staring at his monitor. I took Warren's hand.

"They tried to electrocute me," he said. "The sleep medicine won't work on me."

"IV valium didn't even touch him," said the internist.

"We were afraid to try dig first," said Warren's doctor. "You can't use defibrillation after you start to digitalize."

I nodded. They had done what they had to do. I tried to soothe Warren who was still very upset. "Where are my pants," he said, "I want to go home."

We watched the monitor as the digitalizing doses were injected into the IV tubing. After what seemed a long time, the PAT subsided into plain atrial tachycardia. We sighed. Thank God.

"I called for you," said Warren, "when they tried to electrocute me."

"I heard you but they didn't want me here."

"They didn't tell me what they were doing. If they had just said something, I could've steeled myself for the shocks. I would've cooperated, no matter how I felt."

There it was again. In their haste to save the body, the medical team had forgotten the human being. Would it help Warren if I agreed with him? How would it affect his stay in the hospital? Putting myself in the place of the evening nurse, I bowed my head. Who knows whether I would have thought of it soon enough. After all, they'd had to convert him to a less dangerous arrhythmia the only way they could. "They didn't have time, dear," I said. "They were worried about your heart."

"Stay with me now, and hold my hand," he said, with tears in his eyes. I could feel his hurt, his helplessness, the effect of this insult on his self-image. I felt ashamed that this had had to happen to him. I stayed with Warren until the night crew came on.

Seeing me there again, the night nurse said, "You can sit with him, Ruth, but don't talk to him."

I winced at her words. Probably I had tired Warren out last night by letting him talk so much. But I knew he needed to talk. He was a writer, a man of words. It seemed to make him less anxious. But, according to the textbook, this nurse was right. I couldn't claim that I had learned differently.

"He's all yours tonight. I'm going home," I said, walking out.

Over the next few days Warren's physical condition improved. But, when I came in one morning, he remarked, "Don't say anything yet because if I hear one more inane remark..." He rolled his eyes to the overhead sprinkling system. "These nurses are the dumbest bunch."

I stiffened. How dare he! That "dumb bunch" had saved his life! His doctor, he added, was an undeveloped school boy. I turned guiltily, hoping his doctor wasn't standing behind me. "Boy, you sure came back with a bang," I said, adjusting his pillow.

"I like my pillow crumpled," he said, pushing me away. "The doctor was here a while ago. I think he felt uncomfortable because the bedclothes were disordered. He looks as if his mother just stuck a

handkerchief in his shirt pocket and told him not to get dirty."

"Why are you picking on everyone?" I asked. "In the CCU, you don't have to have a neat bed if making the bed tires you. But, if it were me, I couldn't rest in a bed that had the mattress-pad lumped under my back."

"I was waiting for you," he said. "I didn't want the other nurse to touch me."

"Did you insult her?" I demanded.

"Of course not. Anyway, she wouldn't know if I'd insulted her or not." He suddenly grinned. "You know what nursing is to me? Nursing is two strange women wiping your behind. Oh, that's good — I have to write that down."

What was Warren trying to do to me? I was so angry I couldn't speak for a moment. He was a coronary patient. I mustn't get him upset. But this was an unfair game he was playing. He had all the serves.

"I'm sorry if the personnel here are not as sophisticated as you would like, Warren. But they know their business and they're taking good care of you. You may have to look somewhere else for wit and imagination. If you are contemptuous of them, and they know it, they will only give you minimal attention. Is that what you want?"

"Now I see how you got your Bachelor's with a 3.5 average. You had no competition," said Warren in a whisper.

I wanted to slap his face. Instead, I backed away, as if a crocodile had snapped at me. Fury choked my voice, but I managed to keep it low. "You don't know anything about it, so keep your opinions to yourself."

Warren smiled. "I meant it as a compliment. You don't belong with these people."

Oh yes I do, I thought. And I quit nursing six months ago to go into business with that man. How spoiled and cruel Warren seemed to me at that moment. I had told the doctor how much I wanted Warren to live; not just for myself, but because of the good his books did. He was a practical philosopher who lived by his own creed. A tireless artist, he perfected every line until he was satisfied. Mistakes that would never be noticed were painstakingly corrected. I loved his exquisite standards. I loved his sensitivity. I hated his contempt. It was somehow less than noble for him to criticize the kind-hearted people who cared for him. Then to lump the whole nursing profession into one category — and to make me the exception! It was intolerable. I took myself out of there before I exploded.

The day nurse, Gail, listened to my frustration. "Don't you know what he's doing? He's angry. He's hitting out at everybody. He feels helpless. His ego has been hurt. His body has been insulted, starting with the heart attack and including the defibrillator situation. Now he's found a way of venting his anger. I even overheard him telling the lab technician how to find his vein."

"Oh no. He didn't do that, did he?" I groaned.

"It's okay. The lab tech got his blood. Our egos aren't hurt."

"I'm so ashamed of how he's acting," I said.

"Relax. He's not the first patient like him we've had."

I gave Gail a sheepish grin. "I guess I really let him get to me. I wanted him to be a model patient, and when he wasn't, I felt responsible. I get personally offended when someone criticizes nursing because I know how hard our job is."

"He has made a few points, though," said Gail. "Not everyone is able to work with impatient, intelligent people like Warren. Sometimes nurses mouth clichés just like everybody else. Who is perfect?"

"To listen to him, you'd think Warren was. Can you imagine him as a doctor?"

On the day Warren was moved out of the unit, Gail was busy so I pushed his bed down the hall myself. The view from his new room was superb. Rolling green hills with patches of wild flowers.

"The sky is so blue and, oh, look at the hills! I'm so glad I lived. I get to see clouds again."

I drew the drapes all the way back.

"Is today Sunday?" he asked.

"Yes, exactly one week since you were admitted."

"I missed the funnies then. You know, I need to read Prince Valiant. Dear heart, would you get me the papers?"

I looked at him, lying there fifteen pounds thinner. Something in my face brought tears to his eyes. He said, "I love you, Ruth. Thank you for everything." Now he was the man I could love again.

"Welcome back to the world," I said.

"Prince Valiant coming up." ♣

Ruth Wire, the author of "When the difficult coronary patient is your husband," describes herself as "an RN since 1953 and a writer since 1943" when she was just eleven years old. In 1970 she went back to school and obtained her B.S. in Nursing from California State University at Los Angeles. She has had numerous works of both fiction and poetry published and is presently completing her fourth novel which is set on a pediatric orthopedic ward. She continues to practice nursing and works on a part-time basis on a medical-surgical floor in a hospital in Ashland, Oregon, where she is now living.

Names and Faces

Winifred W. Logan, (M.A., Edinburgh; M.A., Columbia; D.N.S., (Educ); R.G.N., R.T.N.) has been appointed executive director of the International Council of Nurses effective April 1, 1978.



Prior to her appointment with ICN, Logan was nursing officer (education), Scottish Home and Health Department, Edinburgh. Her previous posts include those of senior lecturer, department of nursing studies, University of Edinburgh, and chief nursing officer, Ministry of Health, Abu Dhabi in the Middle East, where she was responsible for establishing comprehensive nursing services and training within the hospitals and community and setting up the nursing division of the Ministry of Health. She has also had nursing experience in the United Kingdom, Canada and the United States.

Logan has held several temporary appointments with the World Health Organization including developing in-service education programs in Malaysia, evaluating undergraduate nursing programs in Iraq and lecturing on administration, education and nursing care of the elderly to various groups of nurses.

Logan will head the permanent secretariat of the International Council of Nurses in Geneva, Switzerland. The ICN is a federation of 88 national nurses associations representing close to a million nurses around the world.

Margaret Bradley (R.N., Montreal General Hospital; Dip. Teaching and Supervision and B.N., McGill) has been appointed assistant director of the School of Nursing, Dalhousie University. She has been active in the Registered Nurses Association of Nova Scotia as president in 1972-74 and as a member of the Curriculum Council, the Nursing Service Committee and Chairman of the Social and Economic Committee of the RNANS.

Joyce Perrin has been appointed assistant executive director of the Canadian Council on Hospital Accreditation. Her previous experience includes nursing and administrative positions in hospitals, most recently as director of paramedical services, the Queen Elizabeth Hospital, Toronto.

Perrin graduated with a B.Sc.N. from the University of Alberta in 1959 and from the University of Toronto in Hospital Administration in 1974. She has been active in a number of health-related organizations, including the American College of Hospital Administration, Canadian College of Health Service Executives and was a member of the Medinfo Second World Conference on Medical Informatics.



Perrin will be particularly involved with accreditation and patient/resident care appraisal in the long-term care field. She succeeds **Ferne Trout** who left the Council to become the associate director, patient care services at Shaughnessy Hospital in Vancouver.



Gladys Lennox has been appointed chairman of the Quo Vadis Approach to Nursing Program at the Osler Campus of Humber College in Toronto. Most recently, she was in charge of a program developed by herself in 1972 for registered nurses leading to a degree in community nursing at Montreal's Concordia University, a program that is unique in Canada.

Lennox received her nursing diploma from St. Anthony's Hospital in The Pas, Manitoba. After taking a number of courses in school health services and business administration, she obtained a degree in adult education from Loyola College in Montreal and last summer completed her master's degree in the Department of Social Foundations in Education at McGill University.

Her working experience includes industrial nursing with Hudson Bay Mining and Smelting in Saskatchewan, obstetrical nursing in Manitoba, district nursing with the Department of Indian Affairs in British Columbia, medical nursing in Alberta, and school nursing in Quebec.

Lennox has also been involved in school health coordination and has developed pilot television projects on the subjects of sex education for children, health education for college students and courses in family life education. In addition, she has acted as a participant in health education seminars and travel study programs in Denmark, Germany and England.

Shirley Smale professor at the Faculty of Nursing, Queen's University in Kingston, Ontario has been appointed to a new national committee responsible for following up the recommendations of a second report on health services in penitentiaries.

The first report of the National Health Services Advisory Committee to the Commissioner of Penitentiaries in 1974 was devoted to establishing the role and responsibility of the Medical and Health Care Services Branch and of physicians, dentists and nurses in the Canadian Penitentiary Service.

The second, most recent report, deals with the level of service that can be delivered to inmates. The role of the new committee is to help with the implementation of the report's recommendations.

The appointment of Smale to the committee was made in January by the Solicitor-General.



Cathy Howe has joined the head office of the Canadian University Service Overseas (CUSO) as Health Program Officer.

A graduate of the Royal Columbian Hospital in New Westminster B.C. in 1965, Howe has nursed in a number of specialty areas including a burn unit, renal unit and intensive care. She has taught practical nursing in B.C. and also taught in a post graduate course in intensive care nursing at the Winnipeg Health Sciences Centre.

From 1974-76, she served as a volunteer nurse-tutor with CUSO in Ghana.



Planning next semester's curriculum

Fundamentals

A New Book! HEALTH ASSESSMENT. Stressing the "total person" approach, this superbly illustrated text offers students vital skills and techniques for obtaining a complete health history and performing a thorough physical examination. By Lois Malasanos, R.N., Ph.D.; et al. September, 1977. 538 pp., 769 illus. **Price, \$21.75.**

New 7th Edition! MOSBY'S REVIEW OF PRACTICAL NURSING. Reflecting the expanded role of the LP/VN, this thoroughly revised text incorporates timely new information on patient education and nursing assessment. By an Editorial Panel of Authorities. February, 1978. 398 pp., 21 illus. **Price, \$8.25.**

Medical/Surgical

A New Book! METHODS OF CLINICAL EXPERIMENTATION TO IMPROVE PATIENT CARE. Noted authorities in the field offer students a detailed, yet easy-to-understand treatment of the philosophy, methodology and applications of clinical experimentation. By P. J. Wooldridge, Ph.D.; R. C. Leonard, Ph.D.; and J. K. Skipper, Ph.D. March, 1978. 258 pp., 7 illus. **Price, \$9.25.**

New 2nd Edition! A PROBLEM SOLVING APPROACH TO NURSING CARE PLANS: A Program. This contemporary text clearly demonstrates the problem-solving tools and methods necessary for planning effective nursing care. By Barbara Ann Vitale, R.N., M.A.; Nancy Schultz Latterner, R.N., M.A.; and Patricia Mary Nugent, R.N., M.S. January, 1978. 146 pp., 43 illus. **Price, \$9.25.**

New 2nd Edition! CLINICAL EXPERIENCE RECORD AND NURSING CARE PLANNING: A Guide for Student Nurses. Stressing sound nursing care plans, this useful guide helps students evaluate their clinical strengths and weaknesses and offers timely new material on POMR. By Sister Mary Thomasina Fuhr, R.N., M.S.N. January, 1978. 220 pp. **Price, \$8.50.**

New 2nd Edition! INFECTION: Prevention and Control. Updated and reorganized, this comprehensive new edition provides current guidelines for planning and implementing a sound infection control program. An extensive new list of suggested readings adds to its student orientation. Edited by Elaine C. Dubay, R.N., B.S. and Reba Douglass Grubb, B.S.; with 9 contributors. January, 1978. 198 pp., 48 illus. **Price, \$8.50.**

Critical Care

New 2nd Edition! CARDIAC ARRHYTHMIAS: Exercises in Pattern Interpretation. Help your students interpret and understand arrhythmia patterns — quickly and effectively. This edition offers a timely new chapter on laddergrams. By Mary H. Conover, R.N., B.S. January, 1978. 278 pp., 256 ECG tracings. **Price, \$10.75.**

Maternal/Child

A New Book! MENTAL RETARDATION: Nursing Approaches to Care. Emphasizing a humanistic approach, 21 original articles discuss contemporary concepts in the care of the mentally retarded and their families. Edited by Judith Bickley Curry, R.N., M.S., F.A.A.M.D. and Kathryn Kluss Peppe, R.N., M.S.; with 23 contributors. March, 1978. Approx. 288 pp., 45 illus. **About \$9.75.**

New 6th Edition!

Alexander's Care of the Patient in Surgery

For more than 30 years, nursing professionals have depended on this classic text for an accurate, comprehensive presentation of the fundamentals and procedures essential for safe OR practice. This thoroughly revised edition continues that tradition of excellence — and offers your students a wealth of new features:

- It incorporates a new emphasis on nursing assessment and responsibility.
- More than half of the 2,000 illustrations are new — providing a contemporary look at instrumentation and procedures.
- A totally new chapter focuses on concepts basic to OR nursing.
- Many chapters have been totally rewritten; others extensively revised — all include new illustrations.

New Book!

Instrumentation for the Operating Room: A Photographic Manual

"The range of modern surgical procedures is vast, and each procedure has its own instrumentation requirements. For operating room personnel to assist the surgeon in providing optimum patient care, they must be familiar with hundreds of instruments — names, proper usage, cleaning and sterilization." (From the preface) A student's first OR experience can often be — at best — a time of frustration or confusion. A graphic introduction to OR instrumentation, this unique manual helps students effectively prepare for their role on the OR team. Organized according to surgical specialties, it consolidates a wealth of current information on basic instruments used in the most commonly performed procedures. Illustrations of complete set-ups introduce each section; large, clear photographs of individual instruments follow. Throughout, the author uses only the most common name of each instrument. Students will be especially interested in definitive guidelines for cleansing, sterilization and maintenance requirements. Look through the table of contents for a better idea of this text's coverage!

Look through the table of contents and see for yourself how your students could benefit from this exceptional text.

By Marie Rhodes, R.N.; Barbara J. Gruendemann, R.N., B.S., M.S.; and Walter F. Ballinger, M.D.; with 22 contributors. May, 1978. Approx. 800 pages, 2,146 illustrations. About \$26.50.

TENTATIVE CONTENTS (abridged) Administration of operating room nursing services · Principles of asepsis · Instruments, sutures, and needles · Abdominal incisions and closures; laparotomy; repair of hernia · Gastrointestinal surgery · Gynecological surgery · Cardiac surgery · Orthopedic surgery · Operations on the ear, nose, and throat · Pediatric surgery

By Shirley M. Brooks, R.N., B.A. July, 1978. Approx. 350 pages, 821 illustrations. About \$13.00.

TENTATIVE CONTENTS (abridged) ABDOMINAL SURGERY · Basic laparotomy set · Common duct instruments · Tuboplasty instruments · Nephrectomy instruments · VAGINAL AND RECTAL SURGERY · Bartholin cyst instruments · Basic rectal set · Frankfeldt snare with furgurating unit · ORTHOPEDIC SURGERY · Arthroscope instruments · Hagie pin instruments · Minidriver instruments · Basic total hip set · THORACIC SURGERY · Basic rib instruments · Basic open heart set · EYE, EAR, NOSE, AND THROAT SURGERY · Basic nasal set · Nasal polyp instruments · Myringotomy set · Delicate ear instruments · Retinal instruments · Kelman instruments · NEUROSURGERY · Basic craniotomy set · Neuro micro instruments

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Education

New 2nd Edition! **CURRICULUM BUILDING IN NURSING: A Process.** Reflecting current trends in nursing education, this practical "how-to" text incorporates useful new material on the learning process, theory-building and systems theory. By Em Olivia Bevis, R.N., B.S., M.A., A.A.N. February, 1978. 256 pp., 87 illus. Price, \$10.75.

New 2nd Edition! **THE GROUP APPROACH IN NURSING PRACTICE.** Dr. Marram again explores the group process, and offers a comprehensive new chapter on establishing, maintaining and terminating a group. By Gwen D. Marram, N., B.S., M.S., Ph.D. January, 1978. 264 pp., 1 illus. Price, \$9.75.

New 6th Edition! **SCIENTIFIC PRINCIPLES OF NURSING.** Emphasizing nursing assessment, this comprehensive text presents the physiological, psychological and sociological concepts students need for planning effective, holistic patient care. By Dorothy Elhart, R.N., M.S.; Aaron Cannell Firsich, R.N., M.S.; Shirley Hawke Fagg, R.N., B.S.N., M.R.E.; and Olive M. Rees, N., M.A. February, 1978. 710 pp., 241 illus. Price, \$10.75.

Practical Nursing

New 3rd Edition! **VOCATIONAL AND PERSONAL ADJUSTMENTS IN PRACTICAL NURSING.** This thoroughly revised text surveys the health care system — and the role of the LP/VN within it. A definitive new chapter discusses legal and ethical aspects. By Betty Glore Becker, R.N. and Dolores T. Fendler, R.N., B.S.; with 1 contributor. January, 1978. 190 pp., 29 illus. Price, \$6.50.

Review

New 2nd Edition! **REVIEW OF PEDIATRIC NURSING.** In concise question/answer format, this useful review encompasses the essential elements of pediatric practice, and offers timely new information on drug withdrawal in the neonate. By Florence Bright Roberts, R.N., M.N. February, 1978. 228 pp. Price, \$9.75.

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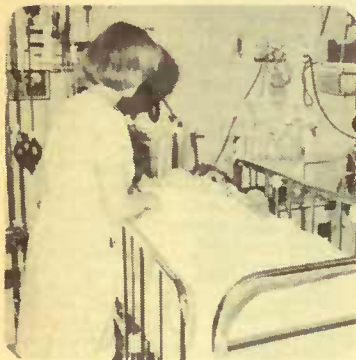
Resumes are based on studies placed by the authors in the CNA Library Repository Collection of Nursing Studies.

Research

• Communication

The Communication Process and Patients' Perceptions while Receiving Mechanical Ventilatory Assistance.

Toronto, Ont., 1977. Thesis (M.Sc.N.), University of Toronto by Margaret I. Fitch.



The study was designed to identify patients' perceptions and feelings regarding their inability to speak while receiving mechanically assisted ventilation therapy. It was thought that this information could have implications for enhancing communication for patients on a ventilator.

The investigator interviewed 30 patients 24 to 72 hours post-extubation. Subjects were questioned regarding their feelings, thoughts and concerns during intubations, their reactions to the inability to speak, the channels of communication used and the perceived success of their communication attempts. Additional pertinent information was obtained from patients' medical records.

The results indicated that the inability to speak was perceived as a source of stress when patients felt a need to communicate but were unable to transmit a message successfully without using speech. Also, the longer an individual was on a ventilator without a satisfactory means of communication, the more apt he was to become frustrated and angry.

Four-fifths (24) of the subjects attempted to communicate in spite of the inability to speak. In all cases, communication attempts were an

effort to satisfy needs for physical and psychological comfort. In particular, subjects found it most difficult to transmit messages pertaining to gaining information about their health status, treatment and progress and thereby satisfy their needs for security and control.

Subjects' thoughts, feelings and concerns while on the ventilator determined whether they attempted to communicate; the success of their attempts, in turn, influenced both their reactions to the inability to speak and their subsequent perception of the situation. In conclusion, the findings suggest that communication with the patient on a ventilator can be enhanced through the provision of specific pertinent information and the clarification of signal transmission.

• Mental Health

Recognition of Loneliness as a Basis for Psychotherapy.

Vancouver, B.C. 1977. Thesis (M.N.), University of British Columbia by Patricia Rose Petryshen.

This study developed a conceptual model for loneliness intervention. Specific loneliness behaviors and suggested interventions to be implemented during psychotherapy were identified in the conceptual model for loneliness intervention. A review of the literature supported the need for research on conceptualizing loneliness to facilitate psychotherapy with lonely clients.

In Part 1 of the study, a control group of thirteen mental health clients who tested high in loneliness were involved in psychotherapy with one of four therapists. Upon completion of six psychotherapy sessions, the clients were again tested for loneliness. Inservice Education on loneliness as developed by the investigator was given. The implementation of the conceptual model for loneliness intervention during psychotherapy was also explained to the therapists. Specific loneliness behaviors and

possible loneliness interventions were inherent in the model.

A new group of eleven clients who tested high in loneliness were identified to the same four therapists. These clients formed the comparison group for Part II of the study.

Loneliness consultation was provided on a weekly basis by the investigator to facilitate therapist implementation of the conceptual model for loneliness intervention. Clients were again tested for loneliness after six therapy sessions.

Analysis of the findings of the study showed that psychotherapy was more effective in reducing loneliness when the conceptual model for loneliness intervention was implemented. Therapists who utilized those interventions with lonely clients found the psychotherapy sessions more satisfying. Therapist perception of client progress in psychotherapy increased when the conceptual model for loneliness intervention was implemented.

The primary recommendations of the study were that:

- loneliness psychotherapy be conducted with mental health clients who are lonely
- that there be further exploration of the concept of loneliness in the field of mental health
- that further research be conducted in a hospital setting on a psychiatric ward where therapy is ongoing.

• Education

Trends in Integrated Basic Degree Nursing Programs in Canada 1942-1972. Ottawa, Ont., 1976. Thesis (Ph.D. Education), University of Ottawa by Marie A. Bonin.

The central question was: What are the trends in the development of basic integrated degree nursing programs within Canadian universities situated in various regions and within specific periods?

Post-basic and basic non-integrated programs were reviewed from 1919 to 1972. However, the core of this study concerned the twenty-two basic

degree programs, within the four university regions, from their inception in 1942 to 1972.

The most salient tendency was the lack of a common pattern in basic degree programs within and among regions. The main trends which emerged were:

- First, there was a mushrooming of basic programs subsequent to the release of the Royal Commission on Health Services. Similar driving forces spurred the establishment of programs and likewise common restraining forces retarded the development of programs in the four regions and within the three periods.

- A second trend was the simultaneous movement perceived through the event of the closure of basic non-integrated programs and the concurrent opening of basic degree programs.

- Third, there is the evolution of nursing educational units in a manner akin to other major health sciences. The trend is now to diminish the general education requirement without necessarily increasing the professional component.

- Fourth, the goals pursued in most basic degree programs tend to be nebulous.

- A fifth trend reflects a balance of liberal arts and the professional component in curricula.

- The sixth trend reveals a continued tendency to experience difficulty in laboratory nursing experience.

- Seventh, there has been individuality and uniqueness reflected in the twenty-two basic degree programs in existence in 1972.

- The eighth trend is that of a relatively small number of admissions, enrolments and graduations within the first and second periods. Since the second portion of the third period there is a marked increase in admissions and enrolments.

- A ninth trend is the paucity of faculty prepared at Master's and doctoral levels.

- The number of baccalaureate graduates tends to still fall short of the ratio established in 1964, namely one professional nurse to four technical nurses.

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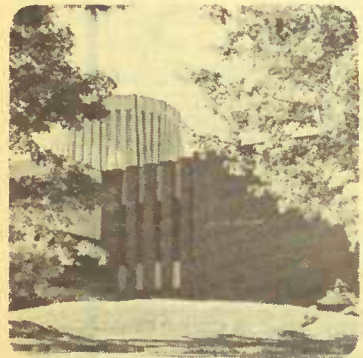
Audiovisual

■ Professional

Your Professional Association



A full color slide-tape show about the Canadian Nurses Association and what it does for nurses in Canada. The presentation spells out the importance of the association to nurses on a local, provincial and international level. It shows the relationship of the association to the development of standards, discipline and ethics. It also takes a look at some of the specific functions of CNA through



research, CNA's Testing Service, Labour Relations Service, the CNA Library and the two journals, *The Canadian Nurse* and *L'infirmière canadienne*. A colorful and lively production. Produced by the Canadian Nurses Association in 1977. Length: 12 minutes. Price for a package of 62 slides, audiocassette and script: \$75.00.

Your Professional Association will be presented at the CNA Convention in the Ontario Room of the Royal York Hotel, Toronto, from 12:30 to 14:00 hours on Tuesday, June 27th, 1978.

In Ontario, there are three ...

A brochure published by the Registered Nurses Association of Ontario. It describes with clarity the three organizations that represent the varied interests of registered nursing and the nursing profession in the province of Ontario. It lets the reader know how each organization — the College of Nurses of Ontario, the Ontario Nurses Association and the Registered Nurses Association of Ontario — has a distinct purpose, each supporting nursing from specific viewpoints. For further information write: Registered Nurses Association of Ontario, Public Relations Department, 33 Price Street, Toronto, Ontario, M4W 1Z2.

■ Step-by-Step

Transfer Techniques

"Assisted Transfer Techniques for a Patient with a Non-Weight Bearing Extremity" provides instruction for a nurse or any other person assisting in patient transfers. Procedures described are for patients with conditions requiring non-weight bearing of the lower extremities, such as fractures and skin grafting, knee replacement, severe sprains, vascular disorders, hip pinnings or amputations.

Step-by-step demonstrations are provided for bed to wheelchair, wheelchair to toilet and return transfers. The basic principles for a safe and efficient transfer are emphasized.

Suggested audiences include nursing staff or students, nursing assistants, physical and occupational therapy students and health educators. 16 mm color film. Length: 9 1/2 minutes.

For information contact: Sister Kenny Institute, Research and Education Department, Publications-Audiovisual Office, 281 Chicago Avenue at 27th Street, Minneapolis, Minn. 55407.

■ Alcoholism

The family of the person with a problem with alcohol

Panel discussion with family members and friends affected by alcoholism. Emphasizes that recovery begins with the family facing the problem, becoming knowledgeable, and doing something about it. Length: 60 minutes. Approximate price \$10.50. For further information, write: Communications in Learning Inc., 2929 Main St., Buffalo, NY 14214.



The physiological aspects of the alcohol abuser

The discussion focuses on the physical results of the abuse of alcohol on the various systems of the body — both organic deficits and deficiencies. Effects on central nervous system, liver etc. are discussed. Length 48 minutes. Approximate price \$10.50. For information contact: Communications in Learning Inc., 2929 Main St., Buffalo, NY 14214.

■ Assessment

Assessment of the patient with arthritic pain

The physical symptoms of rheumatoid arthritis are discussed. Major pharmacological treatment regimes and factors that assist the nurse in assessing the effectiveness of the medication regime are identified. A physical therapy regime aimed at alleviating arthritic pain is included. Length: 17 minutes. Approximate price: \$12.10. For further information, write: Communications in Learning Inc., 2929 Main St., Buffalo, NY 14214

Assessment of the patient in respiratory difficulty

The components of respiration and respiratory insufficiency are identified and defined. The areas of physical assessment which would indicate respiratory insufficiency as well as diagnostic laboratory procedures which would correspond to the nursing diagnosis are also discussed. Includes nursing interventions aimed at alleviating or relieving respiratory difficulty. Length: 26 minutes. Approximate price: \$10.50. For information contact: Communications in Learning Inc., 2929 Main St., Buffalo, NY 14214.

■ Rehabilitation

Rehabilitation after myocardial infarction

An overview of rehabilitation after myocardial infarction is presented. Topics include stress testing, assessment of the patient for an exercise prescription, and the types of physical therapy exercises ordered after myocardial infarction or cardiac surgery. Also included is information on risk factors associated with myocardial infarction and the psychological aspects of recovering from an MI. Length: 33 minutes. 24 slides. Approximate price: \$47.10. For information contact: Communications in Learning Inc., 2929 Main St., Buffalo, NY 14214.

Did you know ...

Women are exposed to more occupational health hazards now than in the past, according to a report by the federal Advisory Council on the Status of Women. The report offers two reasons for the increase: the number of women in the work force is increasing and they are aspiring to a wider variety of occupations, many of them detrimental to health.

Occupational Health Hazards to Women lists the risks to which hospital employees are exposed as — accidents, toxic chemicals, excessive radiation and contact with contagious diseases.

Books

Nursing Assessment, edited by Fay L. Bower, 167 pages. Toronto, John Wiley & Sons, 1977.

Approximate price: \$6.95

"Nursing Assessment" is one volume of a series of Nursing Concept Modules edited by Fay L. Bower. It is published in soft-cover with the internal pages perforated to allow for easy removal of individual sections as necessary.

Bower states that these modules are intended for use by nursing students, teachers of nursing and graduate nurses. This particular volume is a collection of self-contained learning units, each prepared by an individual contributor. The units are intended for use in either nursing school curriculums or staff development programs.

Each section within the text follows the same basic format and includes a pre-test, objectives, directions for use, factual content, periodic progress checks and a post-test. References and a bibliography are also included following each section. The major areas of content covered are: the development of a nursing history, physical exam, psychosocial assessment, nursing diagnosis and the evaluation process.

The text is accurate and comprehensive in the presentation of factual material. Some prerequisite knowledge of the nursing process, normal anatomy and physiology as well as pathophysiology is necessary for any beneficial use of these modules. Motor skills such as the taking of vital signs and usage of an otoscope and ophthalmoscope are necessary to complete the unit on physical assessment. Psychosocial skills including communication and interviewing techniques are needed to complete the sections on nursing history and psychosocial assessment. It is doubtful therefore, that the beginning nursing student would benefit from the use of this text.

In addition, although these modules are intended for independent study, some sections require the use of audiovisual aids such as a slide-cassette and a record which are not included with the text. These particular audiovisual aids are available from California and New York respectively and obtaining them would likely incur further time and expense on the part of the learner. Some sections also require the use of mannikins, practice patients or diagnostic equipment which may not be readily available to the student using these modules independently.

The modules themselves are inconsistent in their presentation. Some sections give explicit directions for the use of the pre-test and progress checks. In other words, unless a specific score is attained, a carefully defined area of content must be reviewed. Other units provide no guidance for

the use of test results. Some units include overall objectives, module goals, specific learning objectives and terminal objectives. Other units contain only one type of objective. Consequently, the reader has to readjust and reorientate himself each time he begins a new section.

"Nursing Assessment" is a text of questionable value for the beginning nursing student lacking in specific skills, or for the graduate nurse who is unfamiliar with the design and use of independent programmed learning units. However this text has definite merit for reviewing or upgrading of skills, or for the acquisition of new knowledge and skills.

Reviewed by Susan J. Carmichael, B.Sc.N., Instructor, Faculty of Nursing, St. Clair College of Applied Arts and Technology, Windsor, Ontario.

Health Assessment by Lois Malasanos et al, 526 pages, St. Louis, Mosby, 1977.

Approximate price \$20.95

Every now and then a reader comes across a book that prompts the thought, "if only I had known about this before ...". This book had that effect on me, because the authors have integrated basic concepts of assessment, interviewing and growth and development along with the standard techniques of history-taking and physical assessment. A rich source of factual information, the book also includes clear and helpful illustrations and tables. These features by themselves ensure the value of the book, and they are enhanced by a writing style that facilitates easy reading.

The text is designed for beginning practitioners who are learning to assess the health status of the client. It is intended for use in conjunction with a course of study that provides structured learning experiences.

The focus of the text is on wellness and the parameters of normal health are included. A discussion of selected problems demonstrates deviations from these parameters. An emphasis is placed on early detection of changes in health status with a view to the prevention of a more serious problem or disability.

The first part of the book presents content to assist the practitioner to gain an understanding of the whole person and individual lifestyles. This includes: the interview and health history, developmental and nutritional assessments and the general survey, in which vital signs are included. This section assists the learner to assess overall function and is followed by the more specific assessment of each body system.

There is a description of the standard techniques of inspection (both direct and by instruments), palpation, percussion and

auscultation. An added attraction is the fuller description of techniques than is usually found and the excellent descriptions and illustrations of the instruments and their use.

The client's history not only includes the chief complaint, present illness and review of systems, but also focuses on daily patterns of activities and sleep and on the developmental stage of the individual. There are separate chapters devoted to the assessment of the pediatric client and the aging client. The last part of the book contains an explanation and example of an integrated screening examination and the recording of it, clinical laboratory procedures, and tables of normal values.

This text would be especially valuable for a nurse practitioner who is preparing for or engaged in primary care, where health maintenance is a priority.

Reviewed by Helen Shore, Associate Professor, School of Nursing, University of British Columbia, Vancouver, B.C.

Helping Cancer Patients Effectively — Nursing Skillbook, by Alyson J. Bochow et al, 187 pages, Horsham, Pennsylvania, Nursing '77 Books, 1977.

Approximate price \$8.95.

This book is written by professionals active in their respective fields. It offers valuable guidance to students and practitioners in developing expertise in the clinical nursing of cancer patients. The authors do not view cancer as a terminal illness, but as one more chronic illness that needs continuous or periodic treatment. They are very successful in putting this view across by updating the advances that have been made, not only in the surgical treatment, but also in the areas of radiation, chemotherapy and immunotherapy.

The book contains the wisdom and experience of dozens of experts actually working with cancer patients. The disease is not viewed with dread (as many people, including professionals, often see it) but with hope in new treatments and an interest in the whole person at all times, not just during a crisis.

The table of contents is divided into five main sections. The first section deals with the very special role of the nurse, "sensitivity" and "patient teaching." The message here is that what you do and what you say depends on how much you care and how knowledgeable you are regarding the disease itself, the current treatments used and their effects on the individual and his family. Then, putting this into perspective, the authors discuss

surgery, radiation, chemotherapy and immunotherapy. The four remaining sections deal with cancer as it affects specific organs of the body and the special nursing care needed so that cancer patients will not be grouped as terminally ill patients.

The authors' stress is on the unique individual fighting for his life with all the usual ups and downs illness brings. Each chapter is concise and to the point and on many pages there is a further summary in the margin of a particular concept, e.g. pain, alleviating alopecia etc. There are excellent illustrations, pertinent graphs, statistics, artwork, actual photographs, and lists of current chemotherapeutic agents.

The skillchecks at the end of each of the five sections present several real problem situations and are an excellent way of assessing knowledge, attitude and skills. These would be excellent for

classroom teaching, ward conferences, or group teaching to patients and their families. The authors' answers are presented at the end of the book, although these skillchecks in most cases would have a variety of answers and act as a means of producing lively discussion.

The message of *Helping Cancer Patients Effectively*, is that man's medical knowledge holds out prospects for a longer, healthier, happier life for cancer patients. Up-to-date knowledge, attitudes and skills are necessary. This book is highly recommended to all who care for cancer patients. The authors are to be congratulated in sharing their knowledge in this concise, practical, beautifully illustrated and worthwhile book.

Reviewed by Eileen (Clapin) French, Assistant Professor, School of Nursing, University of Ottawa, Ottawa, Ontario.

Foundations of Pharmacologic Therapy by Fay L. Bower (Series Editor), 167 pages. Toronto, John Wiley and Sons, 1977. Approximate price \$6.95

In the preface, Fay L. Bower states that "this volume is a collection of learning modules about a specific subject. Each module deals with a portion of the subject and follows the same format — that of pretest: learning objectives; directions; activities; progress checks; and post-test."

The text covers the following self-contained learning modules: introduction to pharmacologic therapy, drug standards and classification, mathematics of pharmacologic therapy, preparation of medications, and administration of medications.

The pretest in each learning module consists of multiple choice questions, matching, and some short answer questions. An answer key is provided. If 80% is obtained on the pretest, the learner is advised to go on to the next learning module. The objectives are written in behavioral terms and are very specific.

The directions are explicit; reference pages are included, based on two pharmacology texts. Other texts are listed as supplementary reading as well as articles at the beginning of each module.

The activities vary in number in each learning module. Most of the activities involve answering questions related to the suggested readings from the two basic pharmacology texts. Progress checks generally take the form of a short quiz.

The post-test questions take the same form as the pretest but the subject matter is tested in a slightly different way. Many of the questions are based on concepts.

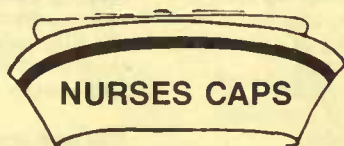
The learning module "Mathematics of Pharmacologic Therapy" deals with both the metric and apothecary systems and also includes conversion between the two systems. Because we use the metric system in Canada, the activities involving apothecary measurements are not relevant.

The learning module concerning administration of medications is based on the so-called traditional method of medication administration using a medication card system as opposed to the unit dose method that some Canadian institutions are using.

I feel that this book could serve a variety of purposes for both the teacher and the student. It allows the student to carry on independent study and is a good text for supplementary reading or course review. It can also free the teacher to spend more time with students needing assistance while allowing students to learn at their own pace.

Reviewed by Dorothy Wood, teacher, nursing education, The Grace General Hospital, Winnipeg, Manitoba.

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Library Update

Publications recently received in the Canadian Nurses Association Library are available on loan — with the exception of items marked **R** — to CNA members, schools of nursing, and other institutions. Items marked **R** include reference and archive material that does not go out on loan. Theses, also, are on Reserve and go out on Interlibrary Loan only.

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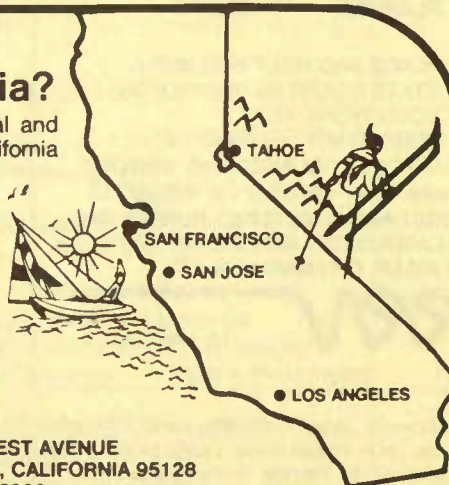
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Registered and Graduate Nurses required for new 41-bed acute care hospital, 200 miles north of Vancouver, 60 miles from Kamloops. Limited furnished accommodation available. Apply: Director of Nursing, Ashcroft & District General Hospital, Ashcroft, British Columbia, V0K 1A0.

General Duty Nurses for modern 41-bed accredited hospital located on the Alaska Highway. Salary and personnel policies in accordance with the RNABC. Temporary accommodation available in residence. Apply: Director of Nursing, Fort Nelson General Hospital, P.O. Box 60, Fort Nelson, British Columbia, V0C 1R0.

Registered Nurses — Full time positions for general duty graduate nurses in 41-bed hospital. Must be willing to become B.C. registered. Submit applications to: Mrs. Norma Baker, Director of Nursing, Golden & District General Hospital, P.O. Box 1260, Golden, British Columbia, V0A 1H0.

General Duty Nurses for modern 35-bed hospital located in southern B.C.'s Boundary Area with excellent recreation facilities. Salary and personnel policies in accordance with RNABC. Comfortable nurse's home. Apply: Director of Nursing, Boundary Hospital, Grand Forks, British Columbia, V0H 1H0.

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Evening Supervisor required immediately for 160-bed General Hospital. Experience essential. For further information contact: Director of Nursing, Yarmouth Regional Hospital, Yarmouth, Nova Scotia, B5A 2P5. Telephone (902) 742-3541 Local 229.

Ontario

Childrens summer camps in scenic areas of Northern Ontario require **Camp Nurses** for July and August. Each has resident M.D. Contact: Harold B. Nashman, Camp Services Co-op, 821 Eglinton Avenue West, Toronto, Ontario, M5N 1E6, or call (416) 783-6168.

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Saskatchewan

Director of Nursing for 21-bed hospital. Some supervisory duties must also be assumed. Employment to commence May 1, 1978 or as soon as possible thereafter. Apply in writing to: Oxbow Union Hospital, Box 268, Oxbow, Saskatchewan, S0C 2B0.

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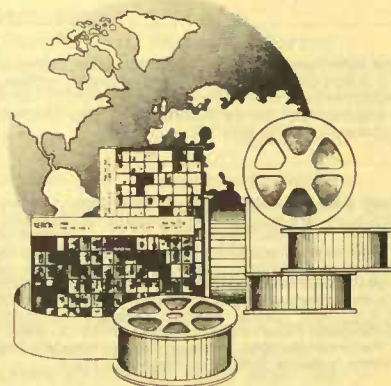
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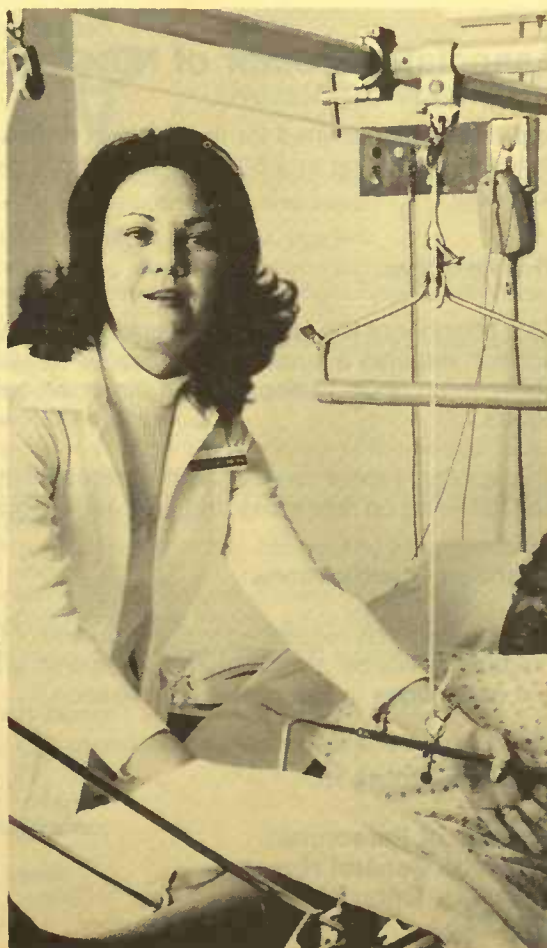
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Applications in writing should be addressed to:

Administrator
Waterford Hospital
Waterford Bridge Road
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A1C 5T9

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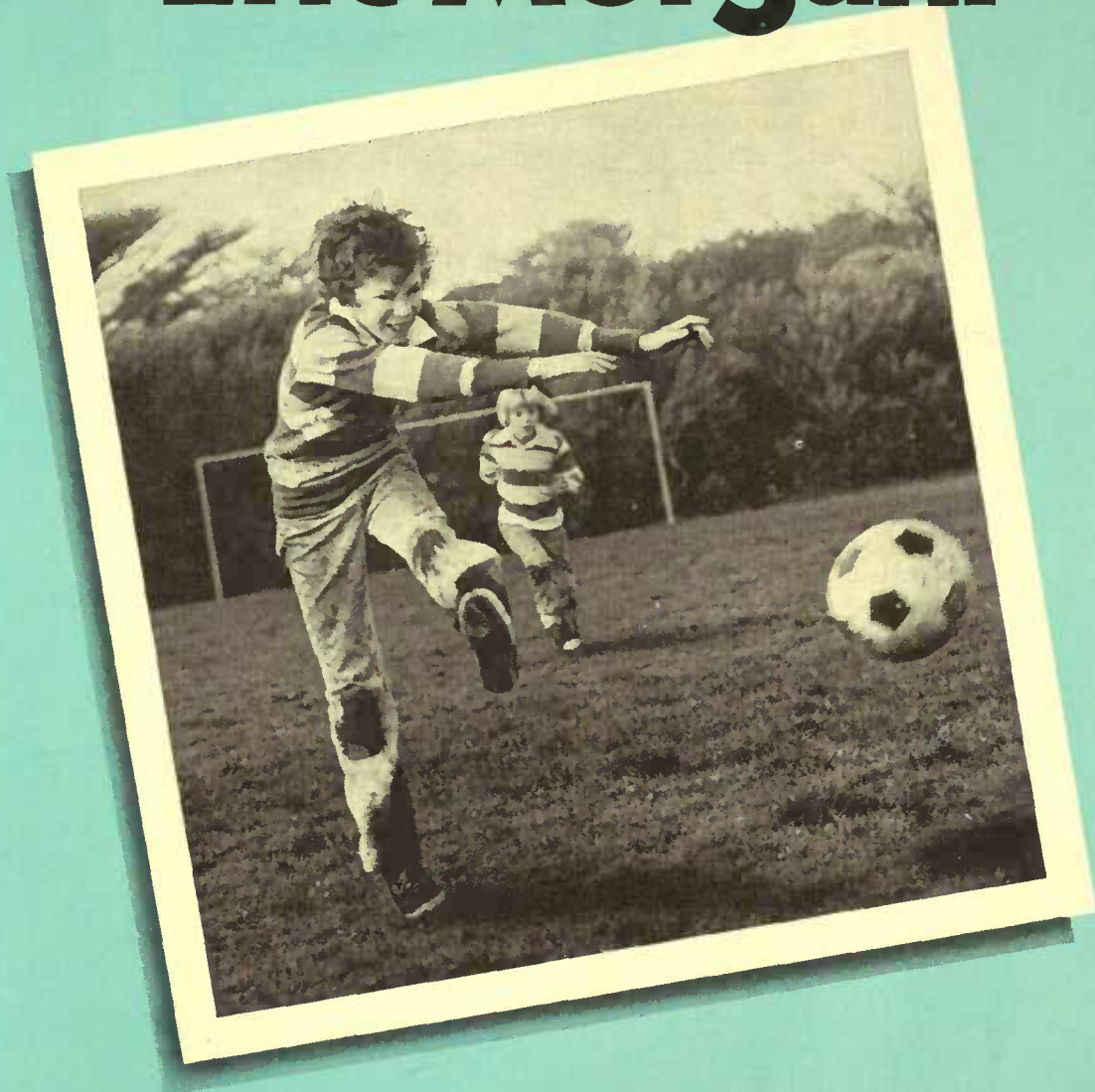
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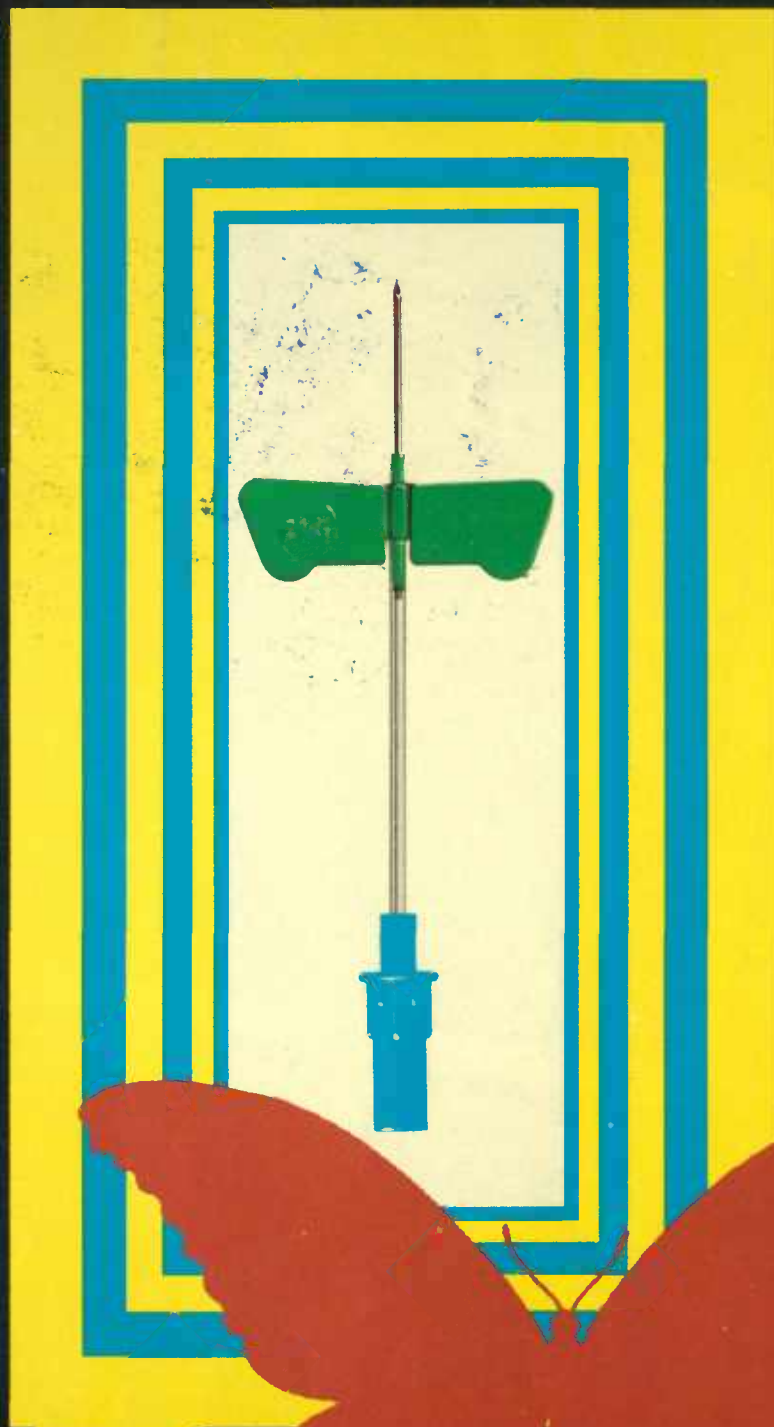
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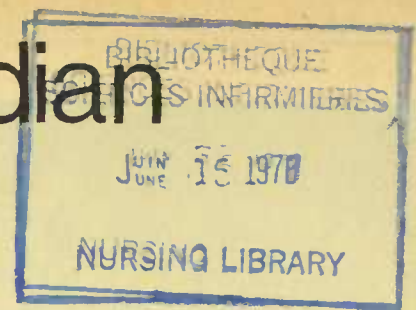
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The Canadian Nurse

JUNE 1978



The official journal of the Canadian Nurses Association published monthly in French and English editions.

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The lakes are "blue with the skies of summer." It is a time for being outside, for celebrating in the sun. The three figures on the cover tell a story of summer, a story that we can share as we participate in all that summer has to offer. (Photo courtesy of Health and Welfare Canada).

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses Association.

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Perspectives

Guest editorial

Fitness: A Challenge for Nurses



Iona Campagnolo, Minister of State, Fitness and Amateur Sport

Nurses have justly earned the reputation of being highly respected health professionals, always concerned with the physical well-being of other people. They usually must cope with a heavy workload in what frequently becomes a highly stressful job.

Consequently, nurses today have a tendency toward maladaptive lifestyles — poor dietary habits, excessive smoking, lack of exercise. It is time for nurses to show more concern for themselves and take a close, critical look at their personal activities and habits.

With the increased knowledge and interest in the benefits of fitness to one's mental and physical health, nurses owe it to themselves to take some of their own advice — and get active! A physically active lifestyle is no luxury these days. Rather, it is an effective means of coping with the stresses of daily life. Too many Canadians, through the neglect of their physical and mental well-being, are pushing their bodies to the verge of bankruptcy, and all so needlessly.

We know that a more physically fit individual is not only a more effective worker, but also just plain *feels better*, in an invigorating, intangible sense. This renewed enthusiasm has a way of spreading itself to friends and family, and nurses, through their work, have the opportunity of passing on this highly

contagious and desirable "fitness bug" to their patients and clients.

The concept of health and fitness promotion is not new. Professional associations, such as the Canadian Nurses Association, all levels of government and a wide variety of groups and individuals have been talking about it for years. But this message has a much bigger impact on the clientele when the promoters first look inwards and take as their campaign platform a personal commitment to a more physically active lifestyle.

As Minister of State for Fitness and Amateur Sport, I am asking — no, I am challenging — Canadian nurses to join the "Fitness Movement" without delay. Pamper yourselves with the far-reaching benefits of an active lifestyle and pass on the word that fitness is great!

Herein

Every nurse has run into a patient like Frank — someone who threatens to turn the entire ward upside down. **This month**, authors Angela Ladyshevsky and Karen Watchorn tell us about their experience with Frank and a plan of action that meant progress for him and satisfaction for his nurses. *I Hope He Gets Transferred Soon* begins on page 26.

A diagnosis of cancer is a devastating experience for any patient. If a nurse understands what the experience means to him and his family in psychological, social and physical terms, she will be better able to care for them. **Next month**, watch for *Psychosocial Aspects of the Cancer Experience* by Pamela G. Watson.

Watch for ... our special Summer edition of The Canadian Nurse.

The July/August issue of *The Canadian Nurse* will feature, besides the normal complement of articles, a special report to membership on the association's celebration of its 70th anniversary at the annual meeting and convention in Toronto on June 25 to 28.

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Input

Under or over

As a new instructor of CPR, please accept my congratulations on your February article on this topic, Cardiopulmonary Resuscitation (CPR) Step-by-Step.

I would like to call your attention to the fact that the information given in the *Unconscious Victim with an Obstructed Airway* (pg. 44) is correct for number 12, however, the photo on page 45 shows incorrect cross finger technique. The thumb must be under the index finger in order to have proper leverage.

—Joan Bohdaniw, R.N.,
Hamilton, Ontario.

Editor's note: Our apologies for the discrepancy between the written information on the cross finger technique and the photo. The official workbook used by the Ontario Heart Foundation in CPR training sessions states that the thumb should be under the index finger. However, other references indicate that the thumb could be over the index finger and still provide the same scissor-like action e.g. Stringer, L.W. *Emergency Treatment of Acute Respiratory Disease*. rev. ed., R.J. Brady Co., Bowie, Maryland, 1973. pg. 18 figure 14.

The truth about the pill

Several reports have appeared recently in the medical literature that describe adverse effects associated with the use of oral contraceptives. Your readers may be interested to know that as a result, a Special Advisory Committee on Reproductive Physiology, a group of non-government consultants has recently reviewed new data concerning the use of contraceptives. Their recommendations

regarding the proper use of these products has been published in the 1978 Oral Contraceptive Report which has just been released.

The committee has provided a brief discussion on some of the current problems associated with the use of oral contraceptives and these are attached, together with a Directions for Use document that was prepared by the Committee and the Health Protection Branch. This will form the basis of all promotional material from the pharmaceutical manufacturers. Also included is a copy of a patient package insert which will be distributed with packages of oral contraceptives in the near future.

A copy of the report is available in English and French from: Educational Services, Health Protection Branch, Ottawa, K1A 1B7. Dr. Ian Henderson, Director, Bureau of Drugs, Health Protection Branch, Health and Welfare Canada.

Professional upkeep

The letter in the March 1978 issue regarding upgrading programs for nurses out of the work force for five years or more is one I wish to comment on.

When I was working as a head nurse in an outpatient clinic, I worked with many nurses taking refresher courses after a few years' absence. I welcomed their presence in our department, particularly their mature outlook and insight into our patients' problems and their superb skills at interpersonal relationships and communications, gleaned, no doubt, from the years spent dealing with their children and families.

Later, as full-time

members of a nursing team, they often commented on how much the course had helped them to brush up on old skills and learn new ones in a supervised setting before being on their own. Also how the new knowledge acquired had bolstered their self-confidence so that when they did take on an assignment they felt ready to deal with the challenge and meet the full needs of their patients in a knowledgeable way.

Hand-holding and soothing the brow are valued techniques in providing TLC but an awareness of our patient's illness and of the medical means used to treat him so we may recognize problems that arise and give them prompt attention is also vital to our care.

If we adopt the attitude that we have learned all that there is to learn on the day we graduate, then we close the door on many growing experiences both personally and professionally. I hope to see more of these courses being offered as well as more ideas for making it easier for all nurses to get continuing education. Then if I decide to work in a new area I can look forward to getting the help I need to obtain the knowledge that will help me to give my best to my new patients.

Secondly, I would like to say 'Hurrah' and 'It's about time' to Corinne Sklar's articles "You and the law" and "Legal consent and the nurse."

How often we hear "well such and such must have been done because it's that shift's job" and then have to rely on the patient to tell us what really happened. If it were all written down it would be so much simpler and confusion and delay avoided. Sometimes, tests and exams are needlessly repeated

because of someone's failure to write down what they did and what their findings were.

I would have liked Sklar to have said just a few words about what should not be included in a chart. I have been appalled by some of the things that I have seen in charts which could only come under the term of 'defamation of character.'

It is not up to us to judge but to state the facts clearly and concisely. Perhaps if we were all a bit more conscious of the fact that the chart we sign may someday be read in a court of law or by the patient for that matter, we would all be ever so much more careful about what we write down and also about how we write it.

Keep up the good work. I am looking forward to reading more of Corinne Sklar's columns in future issues.

—Lynn DePreux,
N.B.Sc.N., Prenatal Class
Teacher, Candiac, Quebec.

More games

I wish to stand up and be counted as one of those supporting the views expressed by David J. Davis in his letter to "Input" entitled *Nursing Conundrum*.

After working at the unit level for a year or more on data finding for a Nursing Manpower Study and Quality Monitoring of Patient Care Assessment, I can most wholeheartedly support his view that "the uniqueness of nursing stems purely from its defiance of rational and acceptable definition," and I am convinced that it is, indeed, "the credibility gap between nursing education and nursing practice" that forces nurses and doctors to continue to "play games."

—Jessie Law, R.N., B.Sc.N.,
Assistant Head Nurse,
Vancouver General Hospital,
Vancouver, B.C.

The Canadian Nurse invites your letters. All correspondence is subject to editing and must be signed, although the author's name may be withheld on request.

'Lupus' clubs beginning

I found the two articles written by Bonnie Hartley on Systemic Lupus Erythematosis and Cortisone (February, 1978) very interesting. It is great that someone is writing about this disease; these are the only Canadian papers that I have come across. Most of the literature comes from the United States.

Alberta is not alone in having a 'Lupus' organization — we in Hamilton began our group in December, 1977. Our first meeting was held in February, 1978 and over 75 people attended. Since then we have held meetings every two weeks. Our membership has risen to over 70, and many families come to our meetings for mutual support. We have an excellent medical advisor, and the response to this "self-help" group has been very rewarding.

— *Joan McKee, President, The Lupus Society of Hamilton.*

Editor's note: Since Joan McKee's letter, the Ontario Lupus Club held its founding meeting at the Wellesley Hospital in Toronto, Ontario. More than 250 people attended. The organization is dedicated to research and to professional and public education about the disease. The Ontario Lupus Club will have an independent board and finances, but will operate under the umbrella of the Arthritis Society. The Lupus Club Board has representatives from Hamilton, London, Toronto, Sudbury and Lindsay and hopes to start chapters elsewhere in the province.

Our mistake

I want to congratulate *The Canadian Nurse* on the very impressive March cover. I was very pleased to see my

pin included with this collection but I have a complaint in regard to its identification.

Pin #11 is actually from Victoria Hospital Training School for Nurses in Fredericton, N.B. This pin is mine, and I'm very proud of it for several reasons. First of all I was in the last class of 1974, at Victoria Public Hospital. The school was in existence from 1889-1974.

The second reason is that the Victoria Public Hospital closed its doors as a general hospital in September.

As these pins are part of the CNA Archives collection, I want to make sure the identification is correct.

— *Victoria J. Rose, Mt. Pearl, Nfld.*

Editor's note: Thanks to all the Victoria Hospital grads who reminded us that the school was located in Fredericton rather than Victoria, B.C.

When the March "Canadian Nurse" came in I want you to know, it caused quite a din! Phone kept ringing ... "Mary, did you see Our VPH pin has been credited to B.C.!"

Now, many long hours Fredericton nurses put in. In order to earn and wear this pin. And to add to our very real consternation. We were not even mentioned on page 3 compilation!

As Archivist of our VPH. It put me in an uptight state. So, if possible, this coming April. Please correct and we'll all be grateful!

— *Mary MacLaren Myles, Archivist, Victoria Public Hospital Alumnae Association.*

Did you know

A booklet just published by the International Council of Nurses calls for collective action by nurses as the basis for improving patient care.

The 18-page booklet, entitled *An Underestimated Problem in Nursing: The Effect of the Economic and Social Welfare of Nurses on Patient Care* was prepared for ICN by Dr. Ada Jacox from the University of Colorado School of Nursing. The booklet contains an analysis of the historical and social forces which have influenced nurses and nursing care — the functions of the nurse, how these functions have been viewed historically as women's work and the

concept of professionalism.

This booklet is available in English, French and Spanish from: *Publications Sales, International Council of Nurses, P.O. Box 42, CH-1211, Geneva 20, Switzerland.*

Did you know...

Medico, a service of Care, the international aid and development agency urgently needs well-qualified nurses and other health service personnel to teach while serving in developing countries overseas. If you are interested, contact: Leonard Coppold, Director of Contract Personnel, Care-Medico, 660 First Ave., New York, N.Y., 10016.

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News

Health and Welfare releases report on oral contraceptives

Recent reports in the medical literature have defined more clearly certain hazards for those women who use oral contraceptives. There is evidence that the use of this medication is associated with an increased risk of non-fatal and fatal myocardial infarction and that this is related to increasing patient age, duration of contraceptive use and cigarette smoking. The relationship between lesions in the liver and pill use is still being investigated. Hypertension has also been associated with increasing amounts of progestogen in oral contraceptives.

These and other adverse effects of oral contraceptive use are discussed in the 1978 Oral Contraceptive Report released in April by the Health Protection Branch of Health and Welfare Canada. The Report is a summation of the work of the Special Advisory Committee on Reproductive Physiology. The committee, composed of 10 non-governmental medical consultants and two special advisors has reviewed the new data and has made recommendations regarding the proper use of oral contraceptives by Canadian women.

Attached to the Report is a document entitled "Guidelines for the Directions for Use in Estrogen-Progestogen Combined Oral Contraceptives" and the text of a patient package insert. The former document is now the basis of all information from the pharmaceutical industry on this topic. The patient package insert will be included in all oral contraceptive packages that are dispensed to patients starting July 1978. (See pg. 8) In developing the patient package insert, the committee and the Health Protection Branch were guided by their conviction that it is the doctor and patient who must decide together whether or not oral contraceptives are to be used and that it is the responsibility of the doctor to inform the patient of the hazards of these products as he or she sees fit.

It is estimated that there are 900,000 Canadian women and 60 million women the world over presently taking oral contraceptives. Not until the late 60's were studies of long-term oral contraceptive use initiated and only recently has speculation about these effects been documented in the medical literature.

In 1976, the sequential oral contraceptive was withdrawn from the Canadian market because data revealed a correlation between its use and the infrequent development of endometrial carcinoma. Since then, other long-term studies have indicated that oral contraceptive use, although highly effective in preventing pregnancy, can result in serious side effects for some women.

Among the side effects described in the Report are:

Venous thromboembolism — This term includes superficial thrombophlebitis, deep vein thrombosis and pulmonary embolism. Recent studies have provided evidence that there is a causal relationship between the amount of estrogen in oral contraceptives and the occurrence of venous thromboembolic disease in women who otherwise do not have other predisposing factors. There is also a small but significant increase in fatal pulmonary embolism in women who use oral contraceptives. The risk of venous thromboembolism is lessened but not eliminated by using low dosage estrogen preparations. It is suggested that once a diagnosis of venous thromboembolic disease is confirmed, oral contraceptives should be discontinued.

Retrospective studies have reported an increased risk of post-surgery thromboembolic complications in users of oral contraceptives. If feasible, the pill should be discontinued one month prior to surgery and be resumed two weeks after discharge from hospital. For patients who have not discontinued its use and who are undergoing major surgery, prophylaxis using low dose heparin subcutaneously is recommended if there are no contraindications.

Myocardial infarction — Two recent reports have confirmed the results of retrospective studies which indicate that there is an increased mortality from diseases of the circulatory system, including myocardial infarction, in oral contraceptive users. The risk of vascular disease is related to the duration of pill use, age and cigarette smoking. The Royal College of General Practitioners and the Royal College of Obstetricians and Gynaecologists (England) proposed a number of recommendations for oral contraceptive use based on these findings. In general, they recommended

that women beyond the age of 30 years should stop smoking if they wish to continue using oral contraceptives. In women over 40, oral contraceptives should be considered for fertility control only in exceptional circumstances and only after the risk/benefit ratio has been weighed carefully by both the physician and the patient.

Cerebrovascular disease — There is an increased risk of thrombotic and hemorrhagic stroke in women using oral contraceptives, which is independent of other risk factors. Women who present with unexplained central nervous system symptoms, which might indicate minor thrombotic events, should discontinue medication.

Arterial thrombosis — There are case reports of mesenteric artery thrombosis in women taking oral contraceptives. This can manifest itself in unexplained gastrointestinal symptoms.

Hypertension — The use of oral contraceptives is associated with a modest but definite rise in blood pressure which is related to duration of use and age. There is also evidence that the degree of hypertension is related to an increasing dosage of progestogen. Blood pressure monitoring at regular intervals is essential. Patients should be instructed to report any abrupt increase in weight, a sign of water and sodium retention that sometimes accompanies an increase in blood pressure. If a significant elevation in blood pressure occurs, medication should be stopped.

Patients with essential hypertension may be given oral contraceptives but only under close supervision.

Neoplastic diseases — Although oral contraceptive use has not been shown to increase the risk of developing breast cancer, particular attention should be paid to women who have an immediate family history of the disease and are therefore more prone to its development. Careful monitoring is mandatory because if a breast cancer develops, estrogen-containing drugs may cause a rapid progression if the malignancy is hormone-dependent. There is no evidence that combined estrogen-progestogen medication is associated with endometrial carcinoma. Nor does current data indicate that oral contraceptive use is directly related to an increased incidence of malignancy in the cervix. However, a suggestion has been

made that the progression of an established dysplasia may be promoted by oral contraceptives. This serves to emphasize that women who use oral contraceptives should have regular Papanicolaou smears as recommended in the Walton Report (See The Canadian Nurse, June 1976, page 13).

Hepatic Function — Hepatic nodules have been reported in women who use oral contraceptives, generally when the duration of use was more than five years. Two types of nodules have been described: focal nodular hyperplasia (or hepatic hamartoma) and liver cell adenoma. Both are uncommon but it appears that there is an increased incidence in women who use oral contraceptives. These lesions should be considered in women who have abdominal signs or symptoms because these nodules have occasionally ruptured and caused fatal intraabdominal hemorrhage. Hepatocellular carcinomas have been reported, but rarely.

Reports have also indicated that an increased incidence of gallstones can occur in those taking oral contraceptives due to changes in the composition of the bile.

Fetal malformations — Fetal abnormalities have been reported to occur in the offspring of women who have taken estrogen-progestogen combinations in early pregnancy. A fetus which has been exposed to oral contraceptive hormones during the first three months of pregnancy seems to have an incidence of congenital malformations of 4-5% compared to the incidence of birth defects in the general population of 2-3%. Therefore, pregnancy should be ruled out as soon as possible.

Ocular effects — Numerous reports have appeared documenting ocular adverse effects associated with the use of oral contraceptives. The problems most commonly seen include intolerance to the use of contact lenses manifested by subjective discomfort and change in visual acuity, increased incidence of ophthalmic migraine and occasional retinal vascular occlusive incidents.

The Report also pointed out that certain laboratory test results are unreliable unless oral contraceptive therapy has been discontinued for 2-4 months. These tests include: liver function tests, coagulation tests, thyroid function, adrenocortical function,

reproductive endocrine profile tests and others.

In light of the potential hazards of oral contraceptive use, the Report emphasizes that a decision regarding who should and who should not be taking oral contraceptives is difficult. The majority of women deciding to use the pill will be young and healthy and have no evidence of conditions that preclude their use.

Before any patient receives a prescription for oral contraceptives a thorough physical examination should be done including a blood pressure determination, examination of breasts, liver and pelvic organs and a Pap smear. Dialogue with the woman documenting her physical and mental health, family and personal history, need for protection against pregnancy and her own ideas about the best method for her to use is essential. The history should also include a complete obstetrical and gynecological history with special emphasis on estrogen-dependent malignancies, diabetes, varicosities or thromboembolic disorders, depressive reactions, hypertension, classical migraine, headaches, jaundice and social habits such as smoking.

According to the Report, the most widely held view today is that "oral contraceptives should be used only for intermittent family planning" and long-term therapy especially in the later reproductive years is not advisable. It goes on to say however, that in healthy young women medication may be continued for several years.

There are well-recognized contraindications to oral contraceptive use:

- thrombophlebitis, thromboembolic disorders or a history of these conditions
- cerebrovascular disorders
- myocardial infarction
- active liver disease
- history of cholestatic jaundice
- known or suspected carcinoma of the breast
- known or suspected estrogen-dependent neoplasia
- undiagnosed abnormal vaginal bleeding
- during the period a mother is breast-feeding
- diplopia or any ocular lesion arising from ophthalmic vascular disease such as partial or complete loss of vision or defect in visual fields

- when pregnancy is suspected or confirmed
- classical migraine.

New and confirmatory data have identified certain patients at a relatively high risk for complications even in the absence of these contraindications. These include patients in the older age group, those who have taken oral contraceptives on a long-term basis, and those who smoke cigarettes.

In older women, the cumulative risk factors pose an increasing health hazard after the age of 35. In view of this, closer observation, shorter duration of use, cessation of smoking and, where possible, adoption of other means of birth control should be considered after age 35. After the age of 40, the Report recommended that, for purposes of fertility control, oral contraceptives should be considered only in exceptional cases and when the risks and benefits have been weighed by both patient and physician.

Data also indicate that the major side effects, those responsible for significant morbidity and mortality, are related to the estrogen component of the combined pill. In the last few years, new products containing lower dosages of estrogen have become available and there is an increasing trend to use those preparations containing 50 micrograms or less of estrogen. These tablets are highly effective in preventing pregnancy and have a lower incidence of adverse effects. The only problem is a slight increase in the incidence of breakthrough bleeding and amenorrhea, especially in the early months of therapy. The patient should be informed of these side effects and only if they persist beyond three months should an alteration in the dosage to a higher level of estrogen be considered. The Report warns that tablets containing 100 micrograms of estrogen should be given only in rare circumstances where lower dosages are unacceptable.

The 1978 Oral Contraceptive Report is being sent to physicians across the country. It is available to nurses in both English and French from: Educational Services, Health Protection Branch, Ottawa, K1A 1B7.

News

PACKAGE INSERT FOR PATIENTS USING ORAL CONTRACEPTIVES

(Product Name) is an oral contraceptive preparation which contains two female sex hormones (give names) in a specific ratio. It has been shown to be highly effective in preventing pregnancy when taken as prescribed by your doctor.

You should know that, as with other medications, this product should not be used by certain women. In a small number of others, potentially serious side effects may occur. Your doctor is in the best position to decide whether or not any conditions are present that pose a risk to you.

If you and your doctor have elected for you to use (Product Name) for the prevention of pregnancy, you should be aware that periodic medical supervision is necessary.

1. Take the tablets only on the advice of your doctor and carefully follow all directions given to you. It is important to take the tablets exactly as prescribed; otherwise you may become pregnant.

2. Contact your doctor at least once a year.

3. Contact your doctor immediately if you develop severe or persistent headache or a change in previously existing migraine headaches, changes in eyesight, pain in the legs, pain in the chest or abdomen, lumps in the breast, menstrual irregularities, if you think you are pregnant, or have missed a menstrual period. If you wear contact lenses, report any significant changes in eyesight or loss of tolerance to the lenses.

4. Oral contraceptives should never be taken when pregnancy is suspected. They will not prevent the pregnancy from continuing and may interfere with the normal development of the baby.

5. If you wish to become pregnant, the use of oral contraceptives should be stopped for at least 3 months to allow your periods to return to normal. Contact your doctor for advice on this and for recommendations on alternate methods of contraception that should be used during this time.

6. Consult your doctor before resuming the use of oral contraceptives after childbirth, especially if you intend to breast-feed your baby. Hormones in oral contraceptives are known to appear in the milk and they may decrease its flow.

7. If for any reason you should require surgery, the surgeon should be informed that you are using oral contraceptives so that you can be correctly advised in this matter.

8. You should know that there is a relationship between cigarette smoking, increasing age, and heart attacks. Adding oral contraceptives to any of these increases the risk of heart attacks. Women over 30 years of age should consider cessation of smoking if they wish to continue on the pill.

9. After the age of 40 years it is inadvisable to use oral contraceptives. Your doctor should be consulted in this regard.

NWTRNA Annual Meeting

Close to 80 nurses from various communities all over the Northwest Territories met in Yellowknife early in April for the biennial meeting of the Northwest Territories Registered Nurses Association (NWTRNA) and an educational program focusing on crisis intervention.

Nurses from Frobisher Bay, Hay River, Fort Smith, Pine Point, Fort Resolution, Inuvik and Yellowknife discussed and passed two resolutions:

- to look into the feasibility of having a continuing education consultant; and
- to look into the possibility of making continuing education mandatory for continued active registration in the NWTRNA. Membership also voted in a new

president-elect, **Moir Cameron** of Yellowknife. **Sharon Tracek**, of Hay River is president of the association for the 1978-79 term, and past-president is **Barbara Bromley** of Yellowknife.

A two-day workshop on crisis intervention was conducted by **Dorothy Burwell**, a consultant and clinical specialist at the Clarke Institute of Psychiatry and Sunnybrook Medical Centre in Toronto. Burwell led the participants through a review of what a crisis is, the phases and factors involved, and steps that should be taken to help a person resolve the crisis. Participants had an opportunity to meet in small groups to discuss problems they had encountered in dealing with crisis patients. Dorothy Burwell helped members to discover methods to resolve these problems.

Community representation at the workshop included members

of a number of local organizations: representatives from Northern Addiction Services, Yellowknife Correctional Institute, NWT Mental Health Association, Family Planning, YWCA and Akaitcho Hall supervisors were among those who attended. Honorary memberships in the NWTRNA were presented to four nurses for their outstanding contribution to nursing in the north. **Lillian Piper** of Fort Smith, **Mae Wright** of Hay River were awarded memberships for their longtime service in nursing. **Helen Sabin** of Edmonton and **Catherine (Kay) Keith** of Ottawa were honored for their contributions to the original drafting of the Northwest Territories Nursing Ordinance.

Among those present at the meeting were **Thomas Dignan**, president of the Association of Registered

Nurses of Canadian Indian Ancestry and **Helen K. Mussallem**, executive director of the Canadian Nurses Association who brought greetings from CNA. Dr. Mussallem was presented with a sealskin hanging for the CNA from the NWTRNA, a tapestry in sealskin that includes crests of NWTRNA, CNA and Arctic scenes.

B.C. hospital offers first E.T. program

Nurses wishing to qualify as enterostomal therapists can now receive certification through a Canadian program offered by St. Paul's Hospital in Vancouver, B.C.

The first of its kind in Canada, the new program is six weeks in length and is being offered six times a year. Registration is limited to three or four students per class and applicants must provide a

guarantee of a primary position on completion of the course.

The program provides instruction and practice in giving comprehensive and individualized care to pre-operative and post-operative patients with abdominal stomas including colostomies, ileostomies, urinary diversions and fistulae. The course content is presented at basic level to registered nurses working with ostomy patients in acute care, home care and residential facilities. On completion of the program the participant is able to assist and collaborate with all members of the health team in the management of these patients.

The course involves a total of 240 contact hours, including 73.5 hours of formal classroom instruction, 141.5 clinical hours and approximately 25 hours of observational experiences. There are now 60 certified enterostomal therapists in Canada and a total of 800 in North America, all of whom obtained certification through programs in the U.S.

The program is offered through the Enterostomal Therapy Department at St. Paul's Hospital which is part of the Nursing Service Department. Staff includes: Maureen Grant, R.N., B.Sc.N., E.T., Nurse-in-Charge, Joyce Field, R.N., B.Sc.N., E.T. and Mariette Turner, R.N., E.T.

The first program in enterostomal therapy was offered in Cleveland Ohio in 1961. The program at St. Paul's is offered with the joint approval of the Registered Nurses Association of British Columbia and the Registered Psychiatric Nurses Association of B.C. It is accredited by the International Association for

Enterostomal Therapy.

Additional information may be obtained from Maureen Grant, Stoma Rehabilitation Clinic, St. Paul's Hospital, 1081 Burrard St., Vancouver, B.C. V6Z 1Y6.

B.C. Nursing Supervisors Group

British Columbia supervisors have formed a special interest group known as the British Columbia Nursing Supervisors' Group or BCNSG. Nurses holding current membership in the Registered Nurses Association of British Columbia who are engaged in supervisory-coordinating positions are eligible for membership.

The group was formed with three purposes in mind:

- to promote educational programs directed towards meeting the needs of those involved in middle-management;
- to communicate recent developments in fulfilling the physical and psychosocial needs of patients;
- to provide an avenue for informal gathering and idea exchange for supervisors from various parts of B.C.

The BCNSG annual meeting was held on May 10th in Kelowna as part of the RNABC Convention. Plans for a fall workshop are now being drawn up by the Education Committee.

Alberta proclaims "Year of the Nurse"

For the next twelve months the Alberta Association of Registered Nurses will be telling the people of that province about the changing and expanding role of the

modern nurse in the present-day society, as Alberta celebrates "The Year of the Nurse."

Designated as a time for recognition of the registered nurse — qualified, concerned, prepared to care — "The Year of the Nurse" was proclaimed on May 3rd by the association's president, Valerie Ayris, at a special breakfast which opened the annual AARN convention in Edmonton.

"The Year of the Nurse" campaign will seek to present through the daily and periodical press, radio, television, and other channels of communication, a full, clear view of the professional nurse in the community including community public health, the isolated rural health clinic, geriatrics, occupational health care, rehabilitation nursing, nursing education, administration and research.

The intention is not only to inform the public and promote the nursing profession, but also to inspire in Alberta nurses a renewed pride in their chosen occupation and a resurgence of their aspirations for continuing education and the widening of their careers. "The Year of the Nurse" symbol is already appearing all over the province on lapel buttons, posters, bumper strips and T-shirts. It proclaims "The Year of the Nurse" and also features the Alberta rose along with the traditional lamp and flame, and includes the slogan "prepared to care."

The program was inspired by and patterned after "The Year of the Nurse" promotion currently in progress in the United States and sponsored by the American Nursing Association, which has given its blessing and encouragement to the Alberta "Year of the Nurse."

Health happenings

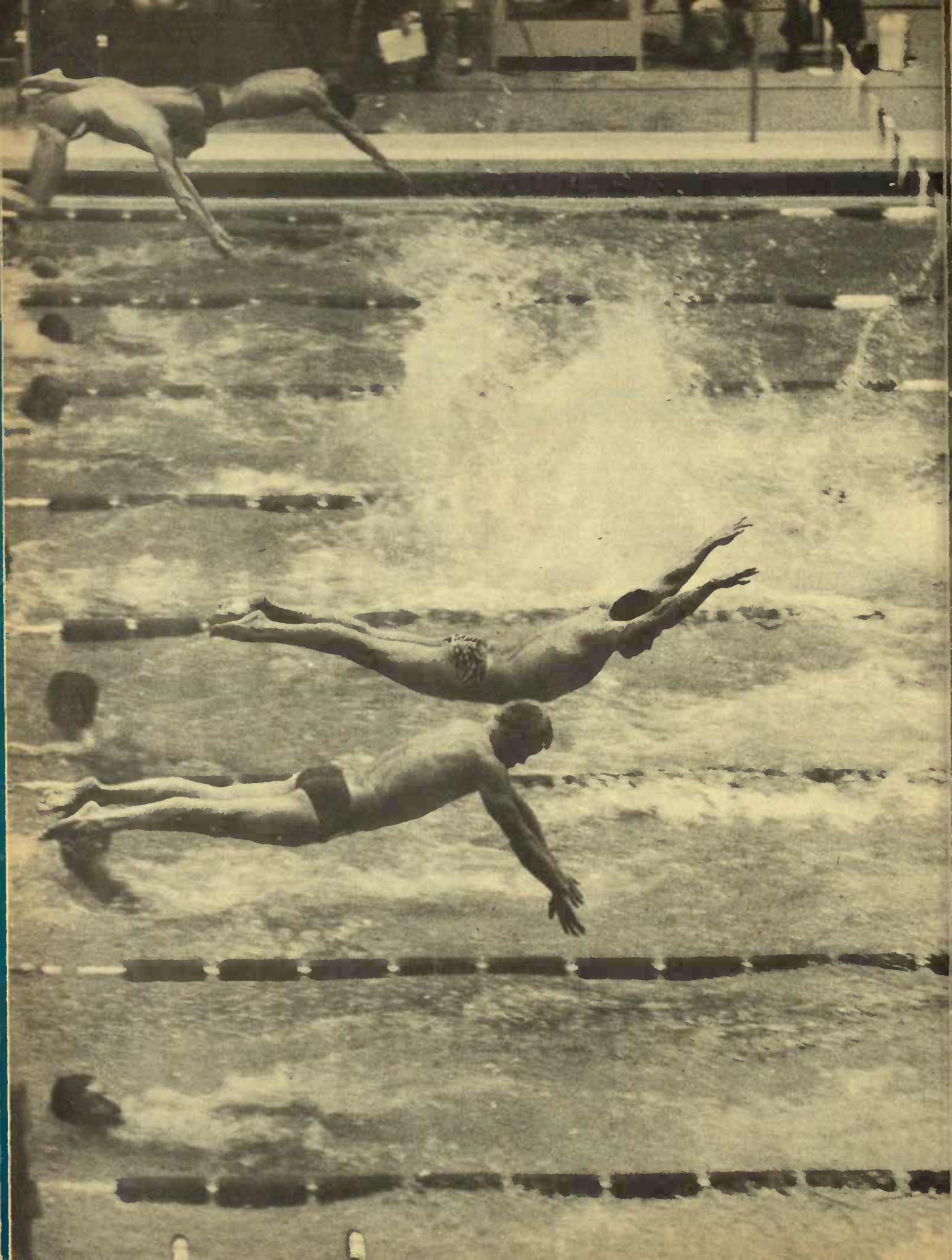
A 12-year-old school girl is among 31 Manitoba patients who have successfully treated themselves at home with intravenous antibiotics rather than undergo a lengthy hospital stay. The patients, who are between the ages of 12 and 78, were taking the antibiotics for severe infections such as osteomyelitis, endocarditis or fungal infections. All patients had been taught how to carry out the treatment while they were in hospital and all were visited daily by a VON nurse once they were at home.

The home treatment has proven to be cost-effective, clinically successful and a preferred method to hospital stay for the patient.

If you reside in the Prairie provinces, you may live longer than those of us in the rest of Canada. A recent document "Health Field Indicators" (Health and Welfare Canada) cites Saskatchewan as having the most impressive record for life expectancy for both sexes, with female longevity at 77.9 years. This is equivalent to rates in Sweden and Norway.

The major reason for this high life expectancy rate in the Prairies is the relatively low death rate in middle and old age from heart disease, cerebrovascular disease and cancer.

On the other hand, the infant mortality rate in Saskatchewan and Manitoba is higher than the Canadian average with a perinatal death rate of 19.9 compared to the overall Canadian rate of 16.7 per 1,000 population. Alberta has the lowest perinatal mortality rate of all the provinces at 14.0 per 1,000 population.



Fitness and YOU

George R. Kinnear Kendy Bentley

No one has to remind you, I'm sure, that your job as a nurse is a demanding one. Turning and lifting patients, moving heavy and cumbersome equipment and walking miles up and down those hospital corridors are reminders of the physical demands made on you each day. And that's not to mention the overall effects that shift work can have on you, both mentally and physically. Granted, all these are in most cases unavoidable hazards of the job. But there is something you can do to help yourself regain some of that physical and mental energy. And that "something" is to be as physically fit as possible.

You have heard about the advantages of physical fitness before: increased enjoyment and satisfaction from work; decreased tension and fatigue; increased productivity and efficiency throughout the day; and enough energy left over to participate in and enjoy leisure time activities. Do you enjoy these advantages now? Or at the end of a shift, do you feel sluggish and tired, hardly able to climb on the bus to go home let alone consider walking home or going for a swim.

If you want these benefits for yourself, and how can you afford not to, then it's time to start a regular physical activity program. Obviously, the main objective of such a program is to develop physical fitness. But what is fitness? Perhaps you'd say that it is being able to lift a patient out of bed effortlessly or to run to the linen room and back in a flash. It's this and more. Physical fitness is cardio-respiratory endurance, muscular endurance, muscular strength, flexibility and weight control. All these factors are components of overall fitness and are

identified as functional capacities (see Table 1). A regular fitness program that emphasizes these functional capacities will improve your physical health and well being.

The exercise program

When thinking about an exercise program, there are a few things to consider:

1. How often should you exercise?

Research suggests that you should exercise at least 3-4 times a week for half an hour each time to attain and maintain a good level of fitness. The time of day you choose to exercise is not critical and will depend on your daily schedule as well as changes due to weather, seasons, shift work etc. If the program is progressive in nature, you may want to exercise more than the minimal half hour and even to exercise every day — it can become an "enjoyable habit."

2. Where is a good place to exercise?

Exercise wherever you have space to stretch out and also do some running without bumping into furniture. The basement can be a good place at home — a gym is best — but adapt whatever facilities you have. Of course, if the weather is nice, try it outside.

3. What about music?

Music with a rhythm or a steady beat is usually great for exercising. Try different types of music to suit your style.

4. What should you wear?

The rule of thumb is to wear whatever is comfortable and keeps you cool.

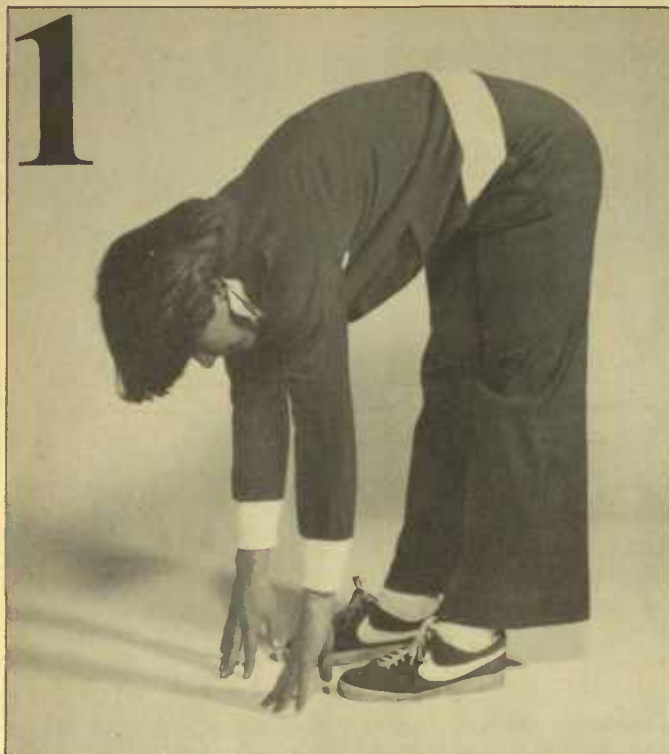
5. Will other changes in your lifestyle occur?

You will find that often nutrition, smoking, alcohol use, and sleep patterns all change for the better, and your mental outlook will be brighter. So what are you waiting for?

Table 1: Functional Fitness Capacities

Cardiorespiratory endurance	Capacity of the heart, blood vessels and lungs to deliver nutrients and oxygen to tissues and to remove wastes.
Muscular endurance	The capacity of a muscle to exert a force repeatedly over a period of time.
Muscular strength	The capacity of a muscle to exert a maximal force against a resistance.
Flexibility	The ability to use a muscle throughout its maximum range of motion. Ability to move joints.
Weight control	Optimal body composition i.e. percentage fat within acceptable range.

1

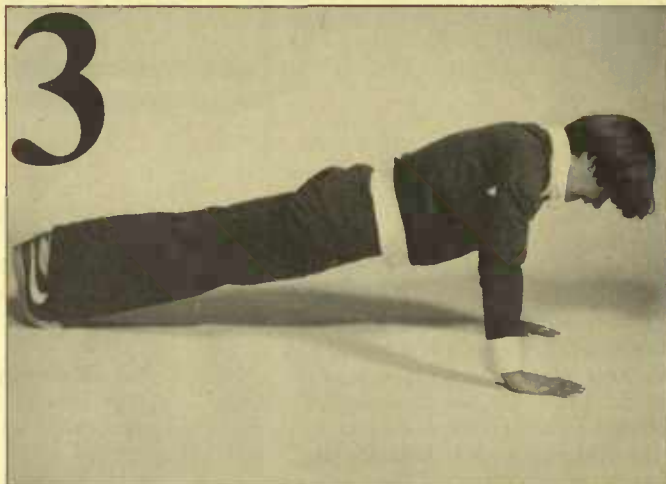
**Part 1**

Every exercise session should begin with a warm-up period. This involves static stretching exercises (figures 1 and 2) for the development of flexibility, followed by a gradual increase in the intensity of body activity (brisk walking, light jogging, skipping). Never neglect this warm-up period. Mild exercise gradually increases your circulation and prepares your body for more strenuous activity. It is also thought that a warm-up puts you in a state of mental readiness for the remaining exercises and helps to prevent muscle soreness.

Part 2

Following the 5-10 minute warm-up, the second part of the session can then concentrate on the development of muscular strength and endurance with particular attention to the upper arms, abdomen and lower back. These two components, muscular strength and endurance, are vital to you in your work since it means less fatigue at the end of a busy day.

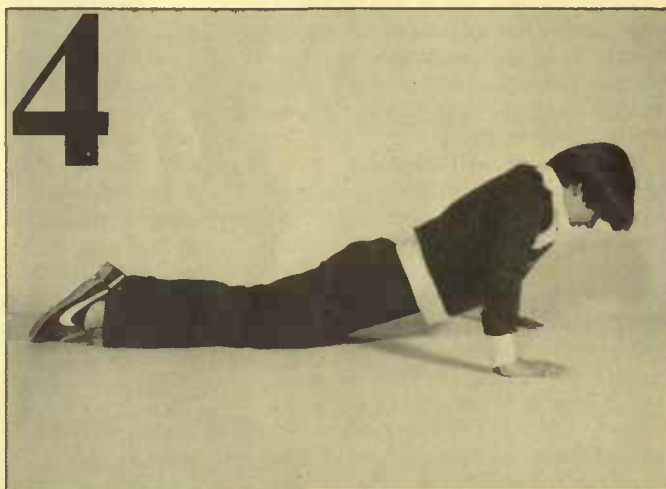
3



2



4



If you are worried about developing "big muscles" with this exercise program, you can put your mind at ease. Research has found that women do not respond to strength development by a significant increase in the size of the muscle, so that big, bulging muscles do not result from strength training.

Push-ups (figure 3) and bar chin-ups will develop the upper arms and shoulders. If your initial strength is poor, then variations of the exercises can be done instead. For example, push-ups may be done from the knees (figure 4) or while standing and pushing away from a wall. Another appropriate variation is the cross-over push-up (figure 5). Chin-up variations include standing on a chair or merely pulling the body as high as possible each time without necessarily lifting the chin over the bar.

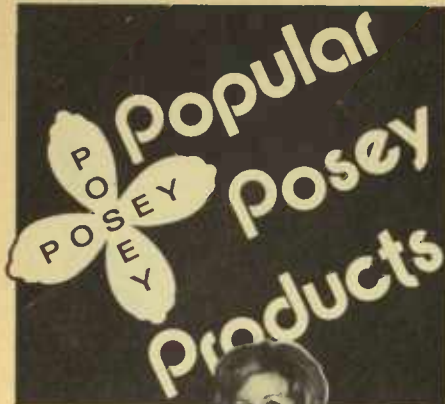
The point is not to overtax your strength at the beginning. Start out with one of the variations and work up to a higher level gradually.



Abdominal muscles can be developed by bent-knee curl-ups (figure 6) and/or variations. For example, you can do only partial curl-ups at first. Knee-ups (lie on your back and pull the knees up under your chin) are also an excellent conditioner for the abdominal region.

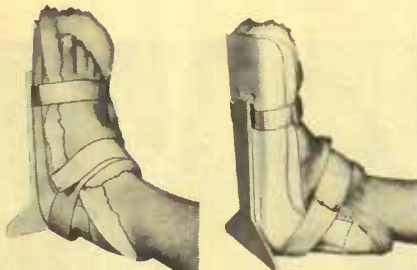
The muscles of the back, especially the injury-prone lower back area can be developed by a number of exercises. Back uprisers (figure 7) are ideal but be careful not to hyperextend your back. Instead, hold the position for a few seconds as shown. Don't attempt to see how high you can raise your upper body.

In addition to concentrating on strengthening the major muscle groups, two other areas are important — the neck and the hand. Your neck muscles can be strengthened by turning your head to one side and then to the other against some resistance by a partner, if possible. (figure 8) Opening and closing your fingers vigorously or squeezing a rubber ball will strengthen the muscles of your hand.



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Part 3

This part of the program is designed to promote flexibility, cardiovascular endurance and endurance and strength of muscle groups such as the thighs. Because these exercises tend to develop more than one component, they are termed "combi-exercises." To achieve their maximum benefit do them quickly and intensely. Here is a suggested exercise sequence. Intersperse the exercises with walking, jogging or high knee lifts.

1. Walking tall (arms reaching high in air).
2. Walking tall and alternately rising up on toes.
3. Walking, opening and closing hands which are held in front, then to the sides, then above the head, then behind back, then one arm out front and the other behind the back, etc.
4. Walking swinging arms forward, backward, one forward, one backward, etc.
5. Walking rotating neck to the left, then to the right, then looking up, then looking down.
6. Hopping.
7. Cross hopping — with each hop the body is turned from side to side.
8. Skipping sideways.
9. Running sideways — trail leg goes in front, then behind.
10. Walking, dragging inner part of foot, then other part.
11. Walking with long steps, lowering hips and stretching legs.
12. Goose step (walk and keep knees straight — toes pointed up).
13. Goose step and straight-arm-swing.
14. Walking with toes pointed out, pointed in, on outside of ankles, on inside of ankles, and then with knees together.
15. Running backwards.
16. Walking on toes only (point feet out while doing so).
17. Walking while turning upper torso from side to side.
18. Add-on exercise. This exercise involves adding segments of exercises to already existing ones.
 - skipping sideways.
 - skipping sideways, and crossing arms in front.
 - skipping sideways, crossing arms, opening and closing fingers.
 - skipping sideways, crossing arms, opening and closing fingers, turning head from side to side.
 - skipping sideways, crossing arms, opening and closing fingers, turning head from side to side and contracting abdominal muscles.

These add-on exercises and their combinations are limited only by your imagination.

When you have finished all three parts of the program, give yourself a

cool-down period by relaxed jogging, slowing down to a walk and doing some stretching exercises. Cooling down helps the body return to normal in gentle stages and also helps to reduce muscle soreness.

Conclusion

The benefits you can attain from a regular activity program are many. You will feel better, have more to offer your patients while at work, experience less fatigue at the end of a day and best of all experience a special "joie de vivre." Isn't 30 minutes a day worth all that? ♡

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YOU AND THE LAW



Can you afford to be a Good Samaritan?

Corinne Sklar

A few years ago there was a major traffic accident on a busy Ontario highway. A young nurse stopped to aid the many severely injured. Emergency treatments that were instituted under her care and supervision resulted in several lives being saved. Afterwards, the incident was widely publicized and the nurse in question was much acclaimed for her action, probably, in part at least, because people in our society tend to avoid becoming involved in a situation like this which involves offering assistance to strangers.

If a nurse stops to give assistance at the scene of an accident what legal liability might attach to her actions? Is there any liability in law if she *fails* to give assistance? Does a climate of increasing lawsuits against physicians and even nurses deter representatives of the "helping" professions from offering their services as "Good Samaritans"? In the United States, studies have shown that the fear of lawsuits is the major deterrent preventing physicians from offering assistance. In Ontario a similar study in 1971 showed that although the physicians who responded described themselves as apprehensive about being involved in a lawsuit, 90 percent of them said that they would stop to offer assistance at a roadside accident. Many jurisdictions, recognizing the apprehension that professionals have about being becoming involved in a lawsuit as a result of offering assistance in such a situation, have passed Good Samaritan statutes protecting physicians and

sometimes nurses from liability arising out of their actions in these circumstances. Do nurses need this legislative protection?

Emergency Situations

The focus here is not on emergency care given in the confines of a medical facility i.e. an emergency ward, a clinic or physician's office. Rather it is on the situation which is thrust upon you: the car accident, the fire, the choking restaurant patron, the response to "Is there a doctor/nurse in the house?"

Do you have a legal duty to act?

At common law there is no legal duty to undertake to rescue or assist a person in trouble. "Whatever moral or humanitarian obligations there may be, there is no obligation or duty in the absence of a statutory provision to give care to a person in an emergency."¹ This is so because since the earliest times our laws regarding civil wrongs (Tort law) have drawn a distinction between "active misconduct working positive injury to others (*misfeasance*) and passive inaction, i.e. failing merely to take some positive steps to benefit or protect others (*nonfeasance*)."² Thus failure to stop and offer emergency aid to accident or other victims does not generally impose any legal liability on the nurse or any other passerby.

However, a legal duty to act may be imposed by statute. In several European countries, e.g. France, the law does impose a positive duty to render assistance to anyone found in distress. This duty is imposed on *all* persons; thus in these countries, it is a crime *not* to be a Good Samaritan.

Also there are certain relationships in law where a failure to assist (*nonfeasance*) results in liability. Such protected relationships include parent and child, husband and wife. The law imposes a duty of affirmative action on such relationships. The Canadian Criminal Code codifies this position.³

Another statutory area imposing a legal duty generally on citizens stems from some Highway Traffic Acts. For example, the Ontario Highway Traffic Act places a duty on everyone in charge of a motor vehicle that is directly or indirectly involved in a highway accident to "render all possible assistance."⁴ In such circumstances, the responsibility for taking affirmative action is clear; passive inaction, inaction, nonfeasance, could result in legal liability.

Thus the law itself does not impose a duty upon strangers to assist one another. Society relies on the operation of altruistic, moral and humanitarian instincts to result in voluntary aid. The professional ethics of the nurse propel her to assist in emergency situations but professional ethical codes do not insist on the taking of such action. It is assumed that professionals likely will volunteer to render their services when such need is ascertained. It is unlikely that a nurse would be faced with a charge of professional misconduct on disciplinary proceedings for failure to volunteer. Misconduct pronouncements generally operate on active conduct within the professional sphere rather than on passive inaction.⁵

Why the fear of lawsuits?

The common law duty arises when the nurse assumes responsibility. Nonfeasance or inaction produces no liability. Misfeasance committed in the course of positive action may result in liability.

Once the rendering of care is begun, then the common law duty of care of nurse to patient arises. However, given the nature of the situation, the common law does operate to protect the nurse who stops to give voluntary first aid to emergency victims.

Standard of care

Common law holds the nurse to *the standard of care expected of a reasonable nurse of similar training and experience in similar circumstances*. The relevant legal standard of care is important because conduct that falls below the reasonable standard of care might amount to negligence and be the basis of a lawsuit. Thus the nurse would not be expected to perform to the standard of nursing care expected in an emergency ward or hospital setting generally. So long as she performs according to accepted nursing standards, given the circumstances in which the care is given, e.g. by the roadside, in a restaurant, the law will not impose liability upon her.

It is also important to remember that a mere error of judgment does not amount to negligence. Perfection, especially in an emergency situation, is never required.

The duty

At common law, the duty between the rescuer and the victim arises once the rescuer has begun to assist the victim and in so doing takes charge of the situation. A rescuer cannot begin to rescue and then stop, thereby making the victim's position worse. This is especially true when the rescuer by commencing his rescue, precludes others from coming to the victim's assistance. Nor can the rescuer just remove the casualty to another place, leaving him so that his plight goes unnoticed by others and thereby making his situation worse. In an American case, a woman became ill while shopping in a department store. She was taken to a small room, to lie down on a cot. However, no further aid was given her; no medical or nursing attendants were summoned. She lay there unattended and unobserved for many hours. The store was found liable because they had begun to assist her and their "abandoning" her in the room had prevented her from obtaining the medical assistance she needed from another source.

Once the nurse begins to administer emergency care, she must follow through.

Good Samaritan legislation

Good Samaritan legislation is designed to encourage the voluntary assistance of physicians (and in some cases, nurses) by exempting qualified practitioners outside of hospitals from liability for injuries resulting from the voluntary rendering of emergency treatment. The Acts usually specify that the volunteer must have acted without expectation of compensation or reward — that is, a gratuitous undertaking. The Acts invariably hold that liability will only be imposed if the volunteer acted with "gross negligence," that is, a standard of care well below the reasonable expected standard.

Many American states have passed such legislation applying only to physicians. In Canada, Alberta is the only province that has passed an Emergency Medical Aid Act⁶ which exempts physicians and registered nurses from liability except where there is gross negligence. Nova Scotia's *Medical Act*⁷ protects only physicians. Newfoundland has prepared legislation similar to the Alberta Act. It protects registered nurses and physicians but this legislation has *not* yet been proclaimed in force.⁸ Other provinces have considered passing such legislation but decided against it because they felt that the common law already afforded adequate protection to those giving emergency aid. In support of this is the fact that successful lawsuits against Good Samaritans are almost non-existent: the law admires and protects the rescuer.

Nurses should be aware of the following:

- Generally, nurses do *not* have to volunteer their services but, if they do, the law will protect them if the care they give meets the standard of a reasonable nurse of similar training and experience in like circumstances.
- Once the nurse undertakes to give care, she must follow through and give all necessary services the situation demands and she is capable of: e.g. stop bleeding, maintain an airway⁹ etc. In other words, give the emergency care to be reasonably expected and appropriately required.

The dearth of legal suits in this area in Canada is evidence of the fact that Canadian law is aware of the difficult circumstances under which a volunteer labors in an emergency. It will protect the Canadian nursing professional who, in accepting the challenge of the emergency situation, acts as a Good Samaritan. 4

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 - 2 Fleming J. *The Law of Torts* 5th ed. Sydney The Law Book Co. 1977 p. 142.
 - 3 R.S.C. 1970, C-34, s. 202.
 - (1) Everyone is criminally negligent who
 - (a) in doing anything, or
 - (b) in omitting to do something that it is his duty to do, shows wanton or reckless disregard for the lives or safety of other persons.
 - (2) For the purposes of this section, "duty" means a duty imposed by law.
 - 4 *Highway Traffic Act* R.S.O. 1970 c. 202 s. 140.
 - 5 However, it should be noted that professional misconduct can apply to a nurse's behavior outside the work situation. Section 12 of the International Council of Nurses Code of Ethics states: "The nurse adheres to standards of personal ethics which reflect credit upon the profession."
 - 6 *The Emergency Medical Aid Act*, R.S.A. 1970 c.122.
 - 7 *Medical Act*, S.N.S. 1969, c.15 s. 38.
 - 8 *An Act to Protect Certain Persons Rendering Aid Following an Accident or in an Emergency*, S.Nfld. 1971 No. 15 (not yet proclaimed in force).
 - 9 For example, if the nurse believed that some surgical intervention (e.g. a tracheotomy) was necessary and if she felt capable of performing it, and so performed it reasonably given the circumstances then the Criminal Code by s.45 also offers her protection from criminal liability.
- Everyone is protected from criminal responsibility for performing a surgical operation upon any person for the benefit of that person if
- (a) the operation is performed with reasonable care and skill, and
 - (b) it is reasonable to perform the operation, having regard to the state of health of the person at the time the operation is performed and to all the circumstances of the case.

*References not verified by CNA Library.



"You and the law" is a regular column that appears each month in *The Canadian Nurse* and *L'infirmière canadienne*. Author Corinne L. Sklar is a nurse and third-year law student at the University of Toronto.

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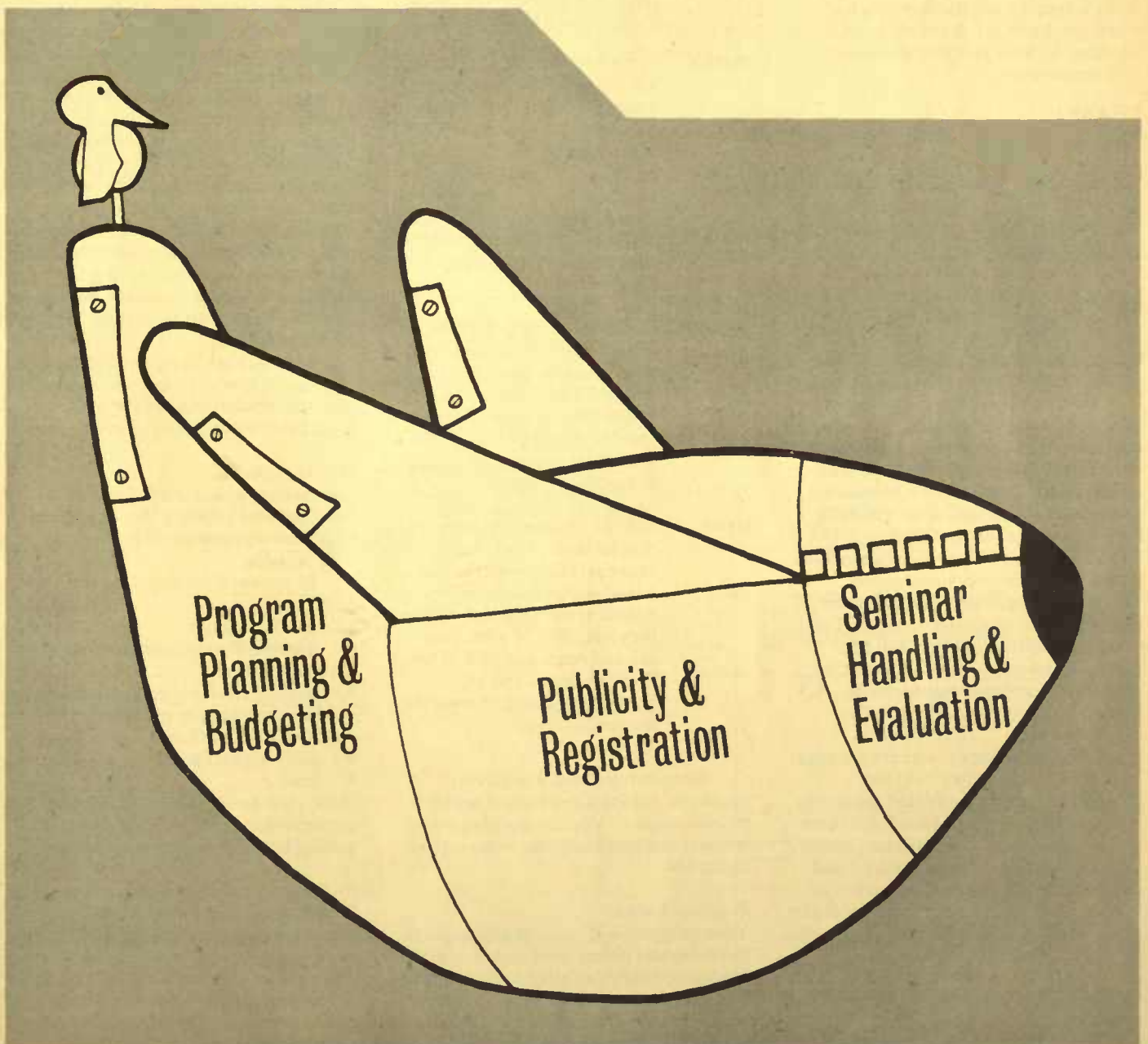
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Cardiac nursing symposiums, orthopedic workshops, seminars on pediatric care, continuing education conferences — they are all interesting, informative and the brainchild of one nurse or a group of nurses who felt that there was an education gap in these areas. Have you ever wondered how meetings like this get started, how YOU could develop relevant education programs in your nursing community? If you have, then read on.

Continuing Education:

Easy Steps to Conference and Seminar Planning

Leslie Joan Key
Marina Heidman



Seminars, symposiums and workshops provide an invaluable opportunity for nurses to participate in continuing education. With the mushrooming of special interest groups across the country, the possibilities for excellent short-term education programs for practicing nurses are just beginning to be realized. But, although many individuals have good program ideas, many just don't know where to begin. How do you turn a good idea for a conference into a reality?

The goal of this article is to provide you with practical guidelines to conference and seminar planning. The checklist format is intended to assist planning committees in implementing an idea and developing an action plan, and in setting time priorities.

Being personally involved in planning a nursing workshop or conference and then seeing it develop is a rewarding learning experience. And don't forget the satisfaction you feel when you know it has been a great success. So start planning for that conference now...

PHASE I

Program Planning and Budgeting

The most basic step is to start planning *early* to allow for adequate organization and for extra time to deal with those unforeseen delays. Six months to one year may be needed to produce the program you want. This time frame allows you some flexibility and minimizes those panic deadlines. Generally speaking, the earlier the more details are finalized, the better.

Select a small planning committee of about six individuals who will remain committed to the project to its completion. Then from this group, select a chairman. Often, the best person for this position is the one who originally had the idea for the conference. Responsibilities of the chairman include coordinating the communications, financial arrangements and decisions reached in the planning meetings. The other committee members will be involved and responsible for publicity, registration, printing requirements, A.V. aids and equipment and hospitality arrangements.

Most committee members are eager to help as much as they can, but sometimes there is confusion about *who* is to do *what*. We have found that there is less confusion if the chairman, rather than a recording secretary, writes and circulates brief informal "minutes" of meetings. These minutes should include: a record of the decisions made during the meeting; a record of the actions and responsibilities to be carried out by each member; and the agenda for the next meeting.

During your initial planning, be

systematic. Consider the following:

- | | |
|--------------|---|
| WHO | is your expected audience? Are you appealing to the generalist or the specialist? Is there a wide range of expertise on the subject in your audience? You might think about co-sponsoring the conference with a related interest group or association. Also, estimate the number of delegates who will probably attend the meeting. |
| WHAT | is your objective? State it in simple terms (i.e. to provide correct information about ...) What is the focus of your program? Are you trying to cover one topic in-depth, or provide a broad overview of many related topics? |
| WHEN | is the best time of year and the best day of the week to have your meeting? Is the weather a factor? Can you meet your objectives in one day or in two days? Remember that planning for two days is just as easy as planning for one, and a two-day meeting offers the possibility of a better program. |
| WHERE | can the meeting be held to offer the best facilities to meet your planning goals and budget? Think about the availability of auditoriums or smaller meeting facilities in your local community college, hospitals, or hotels. |
| HOW | will the program be designed (i.e. lectures, workshops, seminar)? Consider the best use of audiovisual aids. ^{1,2} Adults remember 30% of what they see, 50% of what they see and hear, and 90% of what they see, hear, and are involved in doing. ³ So get the learner involved. |

Keep in mind that objectives, speakers, facilities and budget are all interdependent. You cannot plan one without thinking about the others. (See figure 1)

Program format

Your program will be more attractive to the delegates if they have a choice in the workshops they can attend. (See figure 2). Having two workshops in session at the same time also means that the numbers at each workshop are more

manageable and that there will be a better chance for participation in question periods etc. If possible, it is best if delegates have an opportunity to attend all the presentations. To accomplish this, optional workshops will need to be repeated but this will depend upon the time frame of the program and your speakers. Some of them may not be able to spend all of one or two days at the meeting. In developing the program format, provide adequate time for circulation, breaks and meals. If a luncheon is not provided for your delegates remember that they will need extra time.

Selection of speakers

It is vital to select speakers carefully. They can make or break a conference or seminar. If possible, invite persons whom you know and have enjoyed. They should be knowledgeable, enthusiastic and interested in teaching. It is important to contact nurses as speakers for your meeting since they can address a topic from the perspective your audience is interested in — a nursing perspective. Once chosen, telephone your speakers at an early stage in your program planning and send confirmation letters to each of them. Your confirmation should include details about the "Whos", "Whats", "Whens", "Wheres", and "Hows" as well as specific details relating to their presentation (i.e. the topic, a preferred approach to the topic, length, best format of presentation, and the topics of other speakers).

Also include an information sheet (See figure 3) which your speakers can return to you to help in your overall program development and coordination.

Meeting space

The meeting space itself is a critical item. Several facilities should be seen, evaluated and compared before making a final decision.

In your evaluation of the facilities, consider:

- available dates
- accessibility to transit, meals and accommodation
- seating style and capacity of main and seminar meeting rooms
- space for exhibits
- audiovisual facilities
- cost

Once your decision is made, request confirmation of the meeting space in writing from the appropriate person.

Preliminary publicity and registration

Decide what your overall publicity campaign structure will be. For example, how wide a geographical area do you want to cover — local, provincial or national? If you have lots of lead time, you may consider an initial information poster giving the details of "Who",

Figure 2

Suggested Program Format — Two-Day Seminar

DAY ONE

7:30 — 9:00 Registration
 9:00 — 9:15 Welcome, Opening Remarks
 9:15 — 10:00 Plenary Session
 10:00 — 10:30 Coffee
 10:30 — 11:45 Workshop Sessions (1) (2)

Luncheon (speaker?)

2:00 — 3:15 Workshop Sessions (3) (4)
 3:15 — 3:30 Coffee
 3:30 — 4:15 Plenary Session

(Optional — 12:00 — 6:00 — exhibits, film reviews, etc.)

OPTIONAL EVENING

7:30 — 9:30 Plenary Session/Workshops/Social Function

DAY TWO

9:00 — 10:00 Plenary Session
 10:00 — 10:30 Coffee
 10:30 — 11:45 Workshop Sessions (1) (2) (Repeat)

Luncheon

1:30 — 2:45 Workshop Sessions (3) (4) (Repeat)
 2:45 — 3:00 Coffee
 3:00 — 3:30 Plenary Session
 3:30 — 3:45 Closing Comments

Figure 3

Speaker Check List

Name
 Address
 Telephone
 Brief biographical sketch

Audiovisual Requirements

Please check your requirements.

☐ lectern
☐ microphone. What type?
☐ 35 mm slide projector
☐ 16 mm film projector
☐ electric pointer
☐ overhead projector
☐ mylar roll
☐ pens
☐ flip charts
☐ chalkboard

Handouts

Will you have handouts? ☐ Yes ☐ No
 If yes, please submit six weeks prior for printing.

Bibliography Suggestion

.....

Will you require accommodation ☐ Yes ☐ No

If yes, what dates?

Figure 4

Cost Check List

Fixed Costs

- | | |
|---|--|
| <input type="checkbox"/> Facilities — Main Meeting Room | <input type="checkbox"/> Publicity |
| — Other Meeting Rooms | <input type="checkbox"/> Printing |
| <input type="checkbox"/> Speakers — Transportation | <input type="checkbox"/> Mailing — Publicity items |
| — Meals | — Confirmation to delegates |
| — Accommodation | <input type="checkbox"/> Audiovisual requirements |
| — Honorarium | <input type="checkbox"/> Stenographical help |

Variable Costs

- ☐ Food/Beverage Costs (varies with actual attendance and the number of coffee breaks and menu choices). As another alternative you might consider having delegates find and pay for their own meals.

Figure 5

Budget Formula to Recover Costs

$$\frac{\text{Fixed Costs} + \text{Variable Costs}}{\text{Number of Delegates}} \times 1.5^* = \text{Fee Per Delegate}$$

Example:

If Fixed Costs = \$700
 Variable Costs = \$500
 Number of Delegates = 100

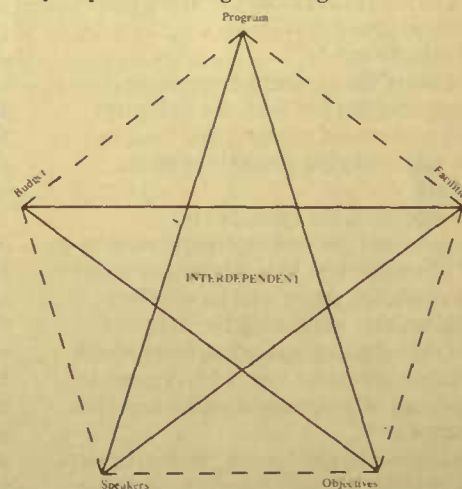
then,

$$\frac{\$700 + \$500}{100} \times 1.5 = 12 \times 1.5 = \$18.00 \text{ per delegate}$$

*50% contingency factor

Figure 1

Key Aspects for Programming



"What", "When", "Where", and "How" to register. This would be followed by your complete program brochure, including an application to register. This brochure could be available at the seminar itself and thus saving double printing. Keep in mind that the quantity and frequency of mailing publicity information has budgetary implications. Estimate all of these costs.

Budget

Preparing a budget may seem to be a difficult task, but good budgeting is absolutely essential. Start by estimating all your fixed and variable costs by using the schedule in Figure 4 as a checklist. Total your estimated costs and add 50% as a contingency factor. Divide this number by the number of delegates you expect will attend, and this will give you your fee per delegate (See figure 5). Make sure to use pessimistic cost estimates (i.e. estimate for high cost) and be conservative in your estimate of the number of delegates you expect.

PHASE 2 Publicity and Registration

Plan to get the conference brochure to print early.

You can take your ideas for the design and layout of the brochure, and make inquiries, obtain time and cost estimates from:

- a graphic and printing company (check the yellow pages);
- community college arts division;
- hospital audiovisual department or print shop.

The brochure should have a catchy title and be colorful with an attractive logo or design, so that it doesn't get lost on some bulletin board. Consider including the following items:

- name, date, place, times
 - objectives of the program (this helps agencies and persons to decide whether the program will meet their needs)
 - the fee and what it includes
 - available parking and accommodation
 - a list of speakers and their current position (this saves lengthy introductions)
 - a list of the planning committee members (this provides the delegates with a source of contact, and besides you ought to give yourselves some credit)
 - name(s) of the sponsors or co-sponsors, as well as others, such as a list of exhibitors. You might also wish to acknowledge those who have offset certain costs of running the program.
 - a detachable application form which clearly states the terms with respect to applicant or program cancellation. (See figure 6).
- Remember to print more brochures than the number of participants, both to use

for publicity and for distribution at the seminar.

Two committee members should be appointed to handle all activities related to publicity, mailing and registration. This includes:

- working on developing mailing lists that include individuals or groups the conference will appeal to
- sending information to date column of magazines and association newsletters at the earliest time possible
- addressing the envelopes while the brochures are being printed
- setting up a card system to record registrations as they are received. From this file, make a master list of delegates.
- preparing signs to be used to direct delegates to meeting rooms and to facilitate registration at the seminar (splitting groups alphabetically)
- developing and printing an evaluation form. Ask simple questions and ask for comments that will provide an opportunity for constructive feedback such as:
 1. Did the program meet your needs?
 2. Comment on the presentation as to effectiveness and level of content.
 3. Is there anything you will do differently because you attended?
 4. Suggestions for content and speakers for future programs.
 5. If you would like to help plan another program, please include your name and address.

PHASE 3 Seminar Handling and Evaluation

One week before the seminar

Registration

Complete delegates' kits with program handouts, evaluation, etc. Make name tags and have additional plain tags available. Split names of delegates into three separate groups to facilitate registration. Have a master list of delegates available at the registration desk. Plan for extra help during the actual registration exclusive of committee members. Don't tie up all your committee members in this activity. They will be required to attend to speakers and to the myriad of small problems that could occur.

Speakers

Specific committee members or helpers should be designated to meet individual speakers and to attend to their needs.

Audiovisual equipment

Make a double check on requests and available AV equipment and be sure that the equipment is operational. The smoothest method is to have an experienced technician on hand during the program to attend to the mechanical problems — the sticking slide tray, the microphone that doesn't work, etc. Also appoint someone to man the lights.

The day of the conference

Audiovisual equipment

Have a rundown check on all equipment, and make sure that extra bulbs, batteries, and overhead pens are available.

Speakers

Committee members or other appointed helpers should meet the speakers and take them to a quiet place. The moderator or technician should tell each speaker about the microphones, manual slide changer and remind them about time limits to avoid clumsy delays. Inform the speakers if the session is being covered by the press.

Remember

Committee members are official hosts and set the atmosphere! At this point, if you've planned well, things should be running smoothly. But be prepared for those unforeseen problems that may interfere with the best laid plans. Use your common sense to correct the problem and don't let it upset you. Keep your cool and enjoy the activities.

Postscript

If you are going to ensure a smooth takeoff and smoother landing for your next seminar or workshop, then your work isn't complete until you have had a post program committee meeting to tie things up.

At this meeting, prepare a summary of the seminar evaluations completed by the delegates and decide how the information is to be used. Ask yourselves if the objectives of the seminar were met. Feedback is an invaluable way to get ideas for new projects, to learn by your mistakes and gain experience in running future efforts. Remember not to be too "thin-skinned" ... you can't please 'em all!

Send thank-you letters to the speakers. They too appreciate receiving participant feedback. Include honoraria and expenses.

Finalize the budget. It may take some time before all the invoices are received, but your program is not over until all the bills are paid.

Congratulate yourselves on a job well done, and start planning your next program early — **YOU'RE IN DEMAND!**

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Figure 6

Sample Application Form

CARDIAC NURSING SEMINAR
REGISTRATION

February 19, 1979

AUDITORIUM A, SMITHVILLE HOSPITAL

Closing date for Registration — January
20, 1979

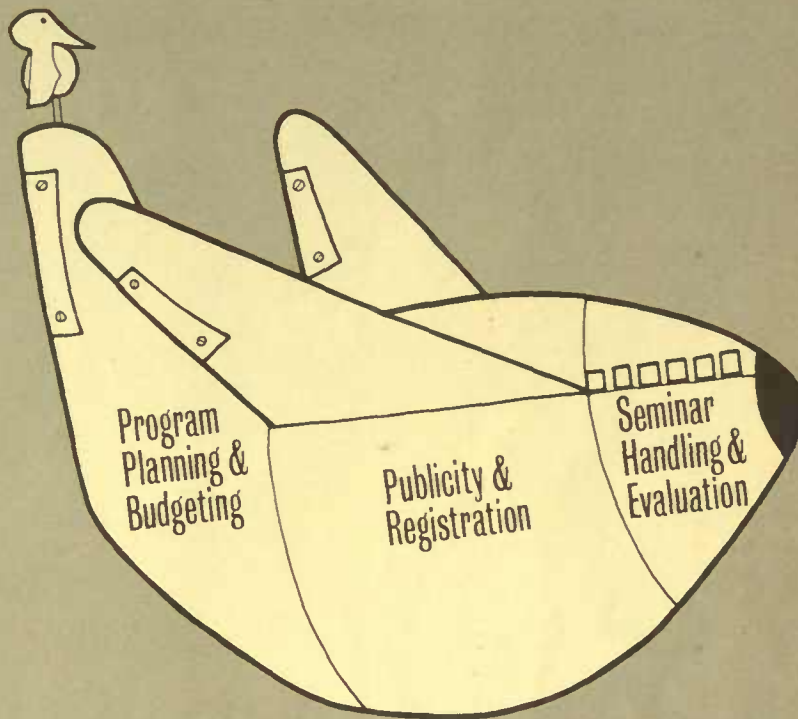
Name

Address

Telephone Agency

Total Fee is \$20.00

Please make your cheque payable to:

Chairman, Registration Committee and
mail it directly to:Mrs. B. Jones,
10 Main Street,
Smithville, Ontario L6T 2S4.Cheque must accompany this
application and cash is not accepted.
Your cancelled cheque is your receipt.Registration is limited and will be
handled on a first come, first served
basis. This application is accepted unless
you are otherwise notified.Cancellations will not be accepted after
January 20, 1979. Substitutes may be
sent.The Committee reserves the right to
cancel unless there are 50 registrants by
January 1, 1979.

Leslie Joan Key and Marina Heidman
co-authors of "Easy Steps to
Conference and Seminar Planning"
have both been involved with
developing, planning and coordinating
several seminars and workshops for
nurses particularly in the field of cardiac
care.



Leslie Key has worked in a wide
variety of hospital settings including
ICU, recovery room, medicine and
psychiatry, as well as being involved in
many educational and professional
activities. She is Southwestern Ontario
Regional Representative of the
Canadian Council of Cardiovascular
Nurses. Leslie is a graduate of the
Wellesley Hospital School of Nursing,
Toronto and is currently a student in the

B.Sc.N. program at the University of
Western Ontario in London.

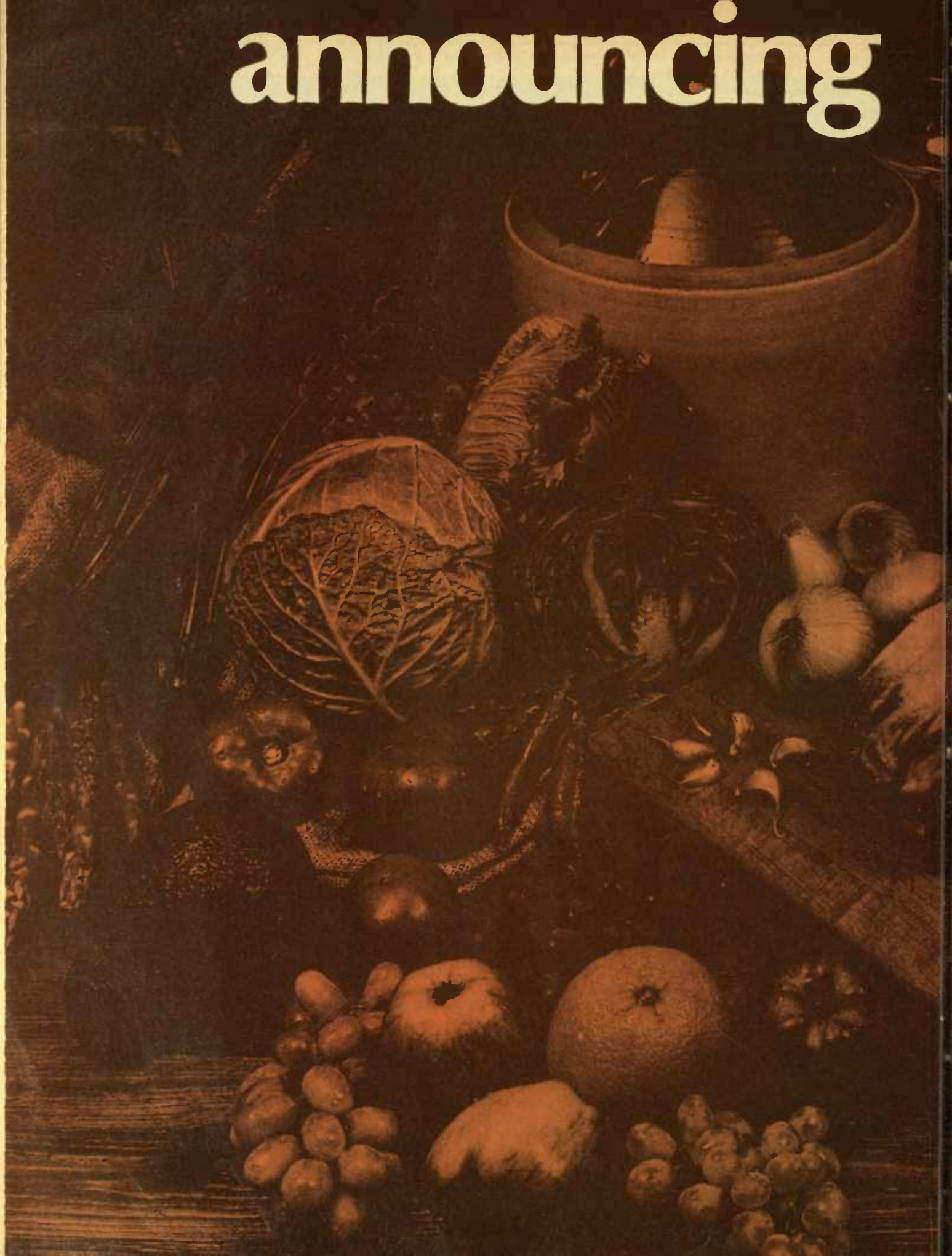
Marina Heidman is teaching coronary
care nursing and is continuing
education co-ordinator for nursing at
Humber College in Toronto. She is a
graduate of the Mack Training School
for Nurses in St. Catharines, Ontario
and has recently completed the CAAT
certificate course in adult education at
the Ontario Institute for Studies in
Education, University of Toronto.
Marina is involved in professional ac-
tivities and has been a guest speaker at a
number of cardiology workshops in
Canada and the USA and will be a guest
speaker at the World Congress of Car-
diology in Tokyo, Japan in September,
1978.

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announcing



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2-in-1 versatility
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tube feeding

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B ROSS LABORATORIES
DIVISION OF ABBOTT LABORATORIES, LIMITED
MONTREAL, QUEBEC

I hope he gets transferred SOON

Frank had the whole ward in an uproar. He cursed and shouted, and rattled his bedrails; he punched his nurses and sent them home frustrated, angry and sometimes ready to cry. A twelve-hour shift with him seemed endless. There seemed to be only one solution and that was Frank's transfer — it couldn't happen too soon for any of us. Until we worked out a plan



Angela Ladyshevsky Karen Watchorn

Frank had become the terror of our unit. Each one of us could feel a mounting sense of frustration when we cared for him; each one of us had to admit (at least to ourselves) that we couldn't wait to see the last of him. Twelve hours with Frank was a long twelve hours.

We hadn't always felt that way. Frank was a 19-year-old boy who had been very badly hurt in a car accident several months ago. When he arrived on

our ward from the intensive care unit, things didn't look so good. He was comatose; he had suffered a certain amount of brain damage and no one knew exactly how much. Frank was in a coma for about two months, unresponsive to our constant care.

And in those two months, Frank had run into his share of complications ... a pneumothorax ... a GI bleed ... and several hypothalamic release syndrome seizures. The seizures were dramatic — his temperature soared to 40.5 C; his

pulse raced at over 200 beats a minute; his respiratory rate reached 60 a minute. During those seizures, his whole body became rigid — he often arched his back right off the bed.

So we were all pretty happy when Frank woke up. He emerged slowly from his coma, growing more alert every day. His seizures were less frequent, and less violent; finally he stopped having them. Frank had fought a long battle and survived. But the job of getting better had barely started.

A care plan for Frank

Communication

Communication was a big problem for Frank and those who cared for him. Many of Frank's tantrums seemed to stem from his frustration over not being able to express himself. We wanted to help him to communicate with us before he felt the need to strike out. And we hoped that by using a positive approach, Frank and staff members could reach a mutual understanding. To tackle the communication problem, we wrote out the following plan:

1. Encourage Frank to ask for the things that he needs. If you can't understand him, encourage him to point to his speech board. Use the board only after you have tried to understand what he is trying to express.
2. Show empathy. Let Frank know that you can understand his feelings of frustration and anger. Tell him that you know he can understand what you are saying, that you know it must be difficult for him to be unable to express himself clearly.
3. Don't talk to Frank as if he were a baby.
4. Get assistance from the speech pathology department, so that Frank can learn from the experts how to express himself more easily.
5. Encourage Frank to slow down, to take time to form his words more clearly.

In the long run, our attempts to improve communication with Frank have paid off. Frank has passed the point where he expresses only his immediate needs. He is able to express concerns about his family and about his education, his interest in hobbies. His sessions with the speech therapist have helped him to make himself understood, and to relate more comfortably with those people he sees each day.

Behavior

Frank's behavior was another all too obvious problem. Certainly any change in his behavior would facilitate communication between Frank and our staff. And if we were ever to succeed in helping Frank to do anything for himself, we had to help him to modify his behavior. This was our plan:

1. Firmly and positively discourage any abusive language or punching. Tell Frank that you don't accept this behavior, and that when he is abusive you will isolate him. Follow this through — draw the bedside curtains around his wheelchair and leave him alone for 10 to 15 minutes (still keeping an eye on him).
2. Tell Frank that you will return when he decides to act appropriately. Keep your promise.
3. Encourage and praise all positive behavior. Pay more attention to Frank when his behavior is appropriate.
4. Don't always run when Frank calls. If his call can wait, tell him that you will return as soon as you can.

Under doctor's orders, Frank was also placed on a regular schedule of sedation. He was given Largactil 25 to 50 mg every four hours. This helped to calm him.

Hygiene

Setting goals for self-care was more easily accessible as far as Frank's hygiene was concerned. By sharing responsibility for his own cleanliness, we hoped that Frank would begin to take other steps towards self-care. And after the first few days following our plan, Frank did in fact begin to do more for himself. This was our plan:

1. Encourage Frank to wash himself as much as he can.
2. Encourage him to take a tub bath twice weekly and prn. Let him wash his hair in the tub.
3. Ask Frank's aunt to bring in some of his own T-shirts and other clothing.

Nutrition

Frank had an incredible appetite, and we saw this fact as a powerful incentive for him to feed himself. But we were also concerned with what Frank was eating. He was on a high protein high calorie diet, with milkshakes in the afternoon and evening. But he also ate a good deal of "junk" food between meals. By meal time, full of pop, cookies and candies, Frank

was no longer hungry. With these problems in mind, our plan incorporated the following:

1. Frank is to feed himself. (Our occupational therapy department had designed a special plate for Frank to allow him to pick up his food more easily.)
2. Prepare his meal tray for him .. cut his meat, butter his bread, etc.
3. Encourage and praise all progress that he makes.
4. Get Frank up in his wheelchair for all meals.
5. Frank is only to have one or two drinks of pop between meals. He may have as much fruit juice as he wants.
6. Frank is not to have any junk food in-between meals. After supper, he may have what he wants, but not before. (This was to ensure that Frank had three balanced meals a day.)

At first, Frank refused to feed himself. Following our plan, we told him that if he wasn't going to eat, we would just take his tray away. Then we left him alone. In spite of his handicaps, Frank's appetite won out in the end — he began to feed himself. He even asked for seconds. And we were pleased with his progress. So, it appeared, was Frank.

Elimination

Frank very often urinated over the siderails or from his wheelchair onto the floor. He also had problems with constipation. So our plan included the following:

1. Encourage Frank to ask for his urinal and bedpan.
2. Give him natural laxative foods such as bran, prunes, etc.
3. Offer laxatives on a prn basis and keep a record of his bowel movements.

At first it was impossible for Frank to sit on a toilet or commode chair because his spasticity made him slide right off the chair. When his hip contractures began to relax however, he was able to use the commode chair. He was very pleased when he was able to use the bathroom instead of a bedpan.

Frank was never really consistent in asking for the urinal. However he managed to tell us that he needed it once in a while, and this was quite an improvement. He always asked for the bedpan if he needed it.

Sleep, rest and activities

Before we started to work on our care plan, Frank seemed to be awake around the clock, from early morning through the day and on into the night. This lack of sleep didn't do wonders for his mood or behavior; he was irritable and tired. And so we tried the following:

1. Put Frank to bed after lunch for a rest period of one to two hours.
2. Keep Frank in his wheelchair for supper and for part of the evening. (We hoped that this would tire him out and help him to sleep through the night).
3. Give Frank sedation routinely according to doctor's orders. When we applied this plan consistently, Frank began to sleep better through the night. He would awaken at about 0800 hours, more refreshed and brighter. His daily activities tended to come easier, and proved less frustrating to him.

In considering Frank's activities, we had to consider the limitations of the facilities and Frank's physical capabilities. At the same time, we had to remember that at the time of his accident, Frank had been a typical active 19-year-old; now he sat in a wheelchair, day in and day out. For this reason we made an effort to:

1. Sit Frank outside his room in the hallway for extra stimulation. Take him outside when the weather is fine.
2. Encourage Frank to wheel himself around. (He was quite good at it).
3. Find out his interests and hobbies, and see what can be done about them.
4. Seek the advice of the occupational therapy department and see what services they have to offer him.
5. Talk to him ... about his progress, physiotherapy, his family, his job, etc. Frank is interested in cars, likes to look at magazines.

A long twelve hours ...

When we first removed Frank's Levine tube, he had begun to make progress by taking fluids very well. Progress was sweet, but short-lived. In a few days, Frank refused to eat anything; in fact, for five days he lived on next to nothing.

The staff responded with motherly concern about his nutritional status. We started to feed him ourselves (under threat of a Levine tube) and bring him his favorite foods. An aunt that Frank lived with was a constant and generous visitor. She brought him milkshakes and chicken, french fries and hamburgers, and Frank's appetite responded remarkably.

There were times when the staff was busy, and Frank's aunt wasn't there. Frank would then have to eat hospital foods; none of us were available to run to a restaurant. Then the tantrums started, Frank gave way to physical and verbal abuse of anyone in sight whenever he didn't get his own way. He punched his nurses. One nurse, particularly unfortunate, wound up with a bleeding nose and a swollen eye.

There were other difficulties. Because of brain stem damage, Frank had certain physical deficits. His whole body was spastic; this affected his legs especially. The range of motion exercises we did with him could not prevent the contractures that resulted from his severe spasticity. He had foot contractures with severe plantar flexion.

Although he could move his arms well, his fingers were contracted. Fine movements were difficult. And though his comprehension was excellent, Frank's speech was affected by his spasticity — he was really difficult to understand. When we didn't understand, Frank would become frustrated and angry, and that's when the punching began.

So Frank turned out to be one very abusive individual whose demands for attention were unending. He shook the siderails of his bed, moaned loud and long and whined constantly. And each of us had a turn looking after Frank. We agreed that a twelve-hour shift with Frank was grueling. His nurse could count on arriving home from work frustrated, exhausted and sometimes, ready to cry. The situation got so bad that we could hardly wait until Frank was transferred, removed forever to a rehabilitation hospital somewhere in British Columbia.

But these sentiments weren't getting us anywhere; frustrations were escalating. Finally, we came to the decision that we had to do something, and that something was to reformulate Frank's care plan and follow it religiously. We had already made up one plan at a ward conference concerning Frank's care. Obviously, it wasn't working out. His behavior had deteriorated, he hadn't taken any positive steps. We decided to base our new care plan according to his most basic needs. (See Care Plan, page 27).

Still not transferred

Frank is still on our ward, and our care plan has grown a little as we've looked after him. His bad days seem much easier to handle and we on staff are taking part in his care in a much more, creative way. As each nurse looks after Frank, she contributes details to his care plan.

We have also learned something about continuity of care. We have found out how important it is for each of us to care for Frank in a consistent way — to follow the guidelines. As soon as we were careless in following the plan, Frank let us know. An example of what could happen when our plan was temporarily abandoned occurred when a casual orderly looked after Frank one evening. He wasn't aware of our care plan and consequently fed Frank half of his supper. When a nurse interrupted and asked Frank to feed himself, he threw his fork on the floor and shouted "Feed me, feed me." It took a few days for Frank to begin feeding himself again. We learned that continuity is important, and that communication with all staff members is vital to our success and Frank's.

As for Frank, he has his good days and his bad days, and he has a long way to go. But our plan has paid off for him too. The change in Frank is obvious. Although he still has outbursts, they are not nearly as frequent. He feeds himself, washes himself, and is quite mobile in his wheelchair. From a completely dependent patient, Frank has become more responsible for his own care, doing more for himself every day and appearing more content. Even his speech is becoming easier to understand.

Frank will probably be on our ward for a while. Somehow that fact isn't the nightmare it used to be because we are looking after problems *now*, one by one. And we've stopped waiting for Frank to be transferred. ♣



Angela Ladyshevsky (R.N., St. Boniface General Hospital School of Nursing) is programme coordinator for the provincial region of the Canadian Association of Neurological Nurses. Angela is also actively involved in educational inservice for staff nurses on the neurology unit at St. Boniface.



Karen Watchorn is a graduate of the St. Boniface General Hospital School of Nursing. Karen has worked on the neurology ward at St. Boniface since her graduation.

Living with a congenital anomaly:

how nurses can help the parents of children born with spina bifida to develop lasting patterns of creative caring.

Judith Hendry
Norma Geddes

The birth of an infant with spina bifida is a tragedy for the parents. The responsibility of caring for a handicapped child at home can be a burden. Parents may need an enormous amount of help and support to understand the consequences of surgical treatment, the severity of the anomaly and the future for their child.



Coping with the unique problems of a child born with spina bifida requires innovative parenting and creative problem solving. Depending on the severity of the defect, the parents of a child with spina bifida are called upon to make many adjustments in their own lifestyle. They must adjust, first of all, to the fact that there is a new member of the family. More difficult, however, is the adjustment that they must make to the congenital anomaly itself. During pregnancy they, like all parents, begin to develop an impression of the possible appearance of the infant. Now they must resolve the discrepancy between this impression and the actual appearance of

their son or daughter. They must mourn the healthy baby that they had been expecting before they can begin to cope with the realities of their abnormal infant.⁸

The guilt and fear that many of these parents feel in connection with the birth of an abnormal infant takes a long time to dissipate, especially when it is complicated by the day-to-day problems that most of them must now face ... problems such as increased intracranial pressure, urinary infection, urine retention and/or incontinence, skin breakdown and constipation.

It is hardly surprising that this dual struggle to survive a mourning process because of the loss of a healthy baby,

combined with the need to learn about the complicated care of a handicapped infant, places an immense strain on both family relationships and resources. Sibling rivalry may take on an added intensity because of the extra care and worry directed towards the new family member. If the infant is "high risk" in the sense of being predisposed to recurring urinary infections, hydrocephalus or poor wound healing of the repaired myelomeningocele, the normal process of parenting with all its associated woes and joys may become incidental to the need for crisis resolution.

In hospital

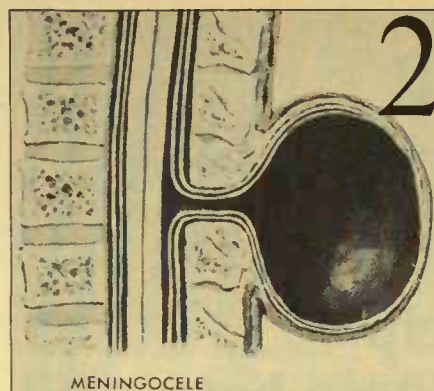
Children with spina bifida *occulta* may require little or no medical treatment, but those with spina bifida *cystica* usually have their meningocele or myelomeningocele surgically repaired as soon as possible after birth, often within the first twenty-four hours of life. In addition, approximately 80-90% of infants with spina bifida *cystica* develop hydrocephalus requiring further surgical treatment.^{5,6} This condition may be suspected if the fontanelles become full, bulging or tense, the head circumference increases in size, the coronal and sagittal sutures become palpably separated or the infant shows neurological signs of increased intracranial pressure.⁷ If hydrocephalus develops, a shunt is inserted which drains cerebrospinal fluid most frequently from the ventricular system to the peritoneum, right atrium or pleural space.

While the baby is in hospital, members of the health team can assist the parents by meeting with them to establish realistic goals so that they can later assume responsibility for meeting the infant's needs in their own home. (See "Peter, an infant with myelomeningocele," *The Canadian Nurse*, January, 1977). Nurses can, for example, teach these parents to feed, hold and bathe their baby, to express his bladder, disimpact his rectum, exercise his extremities, pump the shunt (if necessary), recognize the early signs of intracranial pressure, to know adequate inputs and outputs, and how to provide appropriate stimulation. In short, they can help the parents learn to feel confident in their own abilities to provide adequate care for their baby in spite of his physical defect.

When the parents have reached this stage, when they have learned appropriate methods of meeting their infant's needs, and when the infant is sufficiently recovered, he will be discharged to their care.

Coping at home

The first few weeks at home are almost always an exhausting and frustrating period of adjustment. Parents



Spina bifida is a congenital anomaly in which the two halves of the vertebral lamina fail to fuse posteriorly. There may also be varying associated spinal cord deformities.^{1,2} The two major categories of this defect are spina bifida occulta and spina bifida cystica (see figure 1).

1. Spina bifida *occulta* is a minor defect marked only by a dimple in the skin or a tuft of hair overlying a small fatty mass in the lumbosacral region. In this condition the roots of the cauda equina may be matted together at the level of the bony defect. Patients may be asymptomatic or have intermittent urinary disturbances and reduced sensitivity to pain.³

2. Spina bifida *cystica* is a more serious defect consisting of two main types:

- The meningocele is a cystic extension of the meninges filled with cerebrospinal fluid that protrudes through the unfused vertebral lamina.
- The myelomeningocele is a similar cystic extension in which tissue (i.e. nerve roots, and portions of the spinal cord) is encapsulated.

These defects may occur posteriorly in any part of the spinal column. Most frequently, however, they occur in the lumbar region (40 percent) or lumbosacral region (30 percent).⁴ Depending upon their extent and location, they may result in varying degrees of motor and/or sensory deficits.

The myelomeningocele causes more physical handicaps than any other type of spina bifida and therefore presents the greatest challenge to parents, nurses and other members of the health team.

find it difficult to remain calm when they are constantly on the alert for danger signs such as fever, irritability, vomiting and drowsiness. They tend to forget that their child may also suffer from minor ailments like a cold or an upset stomach. Any sign of illness may become a matter of major significance to the parents causing them anxiety and fear.⁹

It is during these first few weeks or months of the child's life that the family establishes the patterns of caring for their child that will largely determine their child's future physical, social and emotional development as well as the

family's adaptation to this stressful situation. That is why it is essential for the nurse who is helping this family to make a special point of assessing the care patterns that are being developed soon after the infant's initial discharge from hospital.

For the parents of a child with spina bifida, this process of adjustment is a never-ending one. Each phase of their handicapped child's life brings new problems and requires new adjustments on the part of all of the members of the family.

One of the first problems faced by

many parents is the necessity of telling relatives and friends of their child's condition. This concern may persist for many years and is usually the result of fear of the response of their audience. One mother of a ten-year-old child with spina bifida admits that she still dreads making new friends because she has to go through the explanation of her child's problem once more.

Some of the problems of the child with spina bifida are predictable since they relate to the physical handicaps that accompany this condition. They include:

- insensitive skin
- bowel and bladder management
- mobility
- body image and sexuality.

Many of these problems require lifelong management and nurses need to be aware, not only of the problems, but also of current management options that are available. With this knowledge, they can provide the whole family with the teaching, supportive care and early intervention in stress that they need.

Insensitive skin

Individuals with insensitive skin may sustain tissue trauma for many reasons. Sensory loss, motor weakness or paralysis, incontinence and orthotic devices may all predispose children with spina bifida to skin breakdown. In addition to the usual preventive measures for pressure sores, health teaching about the vulnerability of insensitive skin is important. At our center, we provide young children with mirrors to help them inspect their legs and buttocks. Protective clothing for "floor activities" is necessary. The avoidance of environmental hazards such as radiators, sharp objects, abrasive outdoor cement, must all be included in health teaching.

In our adolescent population there have been several patients in the last few years who have consciously or subconsciously induced decubiti in order to gain hospital admission. In one instance loneliness at home set in a cycle of depression, self-neglect, tissue trauma and hospitalization.

The cost of a pressure sore is exorbitant in both psychological and financial terms. In addition, there are serious physiological effects resulting from a chronic sore that are best described by patients when they say "I feel so blah." Preventive measures include:

- maintaining adequate nutrition, hydration, circulation, personal hygiene and ideal body weight
- checking the skin with a mirror at least twice daily
- avoiding extremes of temperature.

In general parents and nurses can be influential in providing the psychological support that the child needs to develop responsibility for his own body image.

The Neurogenic Bladder

Management approaches to urinary incontinence have changed drastically in the last few years. While manual bladder expression (*credé*) and male external collecting devices may still be used, it is really intermittent self-catheterization that has gained the most popularity recently. Surgical intervention such as the ileal conduit, and artificial sphincter (Houston Device) may be used on some patients, if conservative options fail.

Health teaching for parents of infants and children with spina bifida should include both the "why" and "how to" of bladder management. Parents also need to learn early detection of a bladder infection by observing the color, odor, consistency and volume of urine.

We think that, for social reasons, no child over the age of three should wear bulky diapers. If extra padding for bladder or bowel incontinence is necessary, then a custom-fitted diaper should be worn that is both cosmetic and comfortable.

Manual bladder expression (*credé*) is easily learned by children and parents. In some cases, manual expression may not completely empty the bladder and, depending on the health of the uretero-vesical valve, may initiate or exacerbate urinary reflux.

Intermittent catheterization is an alternative to manual expression. Children over the age of five, with good hand function have been taught to carry out this procedure by themselves. Depending on balance skills, children may sit on or stand at the toilet to do the catheterization. This is a clean, non-sterile procedure even though nurses and parents sometimes have difficulty understanding how non-sterile catheterization can reduce and possibly eliminate urinary tract infection. The rationale comes from the work of Jack Lapides, M.D.^{10,11} and his colleagues, who postulate that urinary tract infections occur when there is poor blood supply to the urinary tract because of overdistension or structural abnormalities that lead to decreased tissue resistance. (See also "Intermittent Catheterization," page 34, this issue).

Regular and complete emptying of the bladder, by means of catheterization should help to maintain a small, undistended bladder with adequate circulation. Thus, the advantages include complete bladder emptying, reduction and hopefully elimination of urinary infection and improvement in tissue health in the urinary tract. A perineal urethrostomy may be used in some males with ureteral stricture to facilitate ease of intermittent catheterization.

One mother described her hesitation in letting her daughter catheterize herself

TABLE 1

FOODS CONTAINING "ROUGHAGE"¹⁸

1. Whole grain cereals and bran;
2. Vegetables that retain a crunchy texture when properly cooked, e.g. broccoli, brussels sprouts, cabbage, cauliflower, corn, mushrooms, okra;
3. Tuberous root vegetables, e.g., beets, carrots, parsnips, potatoes, sweet potatoes, turnips;
4. Tough-skinned fruits or those containing edible seeds, e.g., berries of all kinds, especially blackberries and blueberries, dried fruits, tomatoes, eggplant, summer squash;
5. Pod vegetables, e.g., green beans, peas, dried beans, lentils, lima beans;
6. Nuts of all kinds and tortilla chips if made from whole corn and water, popcorn, whole grain pretzels, sunflower seeds, toasted soybeans, raisins, crunchy peanut butter.

because this was a procedure "she (the mother) had always done." This is an example, we think, of the interdependence that may develop between the handicapped child and one or both parents. The possibility of becoming a chronic care-taker, who inhibits independence in the handicapped child, might be averted by skillful health teaching when the child is still young.

External collecting devices currently in use include the pubic pressure appliance and glans condom.¹² The latter is a custom-made condom that is applied over the glans penis with karaya paste. The foreskin is drawn over the condom and waterproof tape is applied around the foreskin. Both the condom appliance and the pubic pressure appliance are fitted to leg drainage bags.

The Ileo-Conduit has been used to ensure social urinary continence as well as to counteract the long-term effects of ureteral reflux. The philosophy of management of individual urologists largely determines the incidence of this surgery. Studies are now becoming available of 10-15 year reviews of this intervention.^{13,14,15}

The Artificial Sphincter (Houston Device) is relatively new. A surgically implanted cuff at the bladder neck is controlled by two valves implanted in the labia in females or scrotum in males. Although the device has gained increasing freedom from technological problems, the problem of tissue rejection remains in some patients.¹⁶ One major positive effect of this device is that it is not visible to others and so the embarrassment in public washrooms is lessened. Also adaptive or protective clothing is not necessary with this device.

Indications of the best management option for a neurogenic bladder may be aided in part by urodynamic studies including intravenous pyelogram,

cystometrogram, bladder neck resistance and cinecystogram. These studies are relatively pain-free and take less than half a day to complete.

While it is the prerogative of the consulting urologist to determine the best management option, it is often the nurse who must interpret that option and guide and support both the family and the child.

The Neurogenic Bowel

"Soiling" is a problem that most parents of a normal infant contend with for less than two years; for the child with spina bifida however, bowel incontinence may be a life-long problem. It is in this management area that we most often hear mothers say "now if you could only help us with this problem." The social effects of the odor and wetness from soiling are tragic: school children don't understand and "make fun" of this problem. Parents feel they must refuse family outings or visits because an "accident" might happen. Again, the nurses' role is one of education and support.

It is the degree of sensory and motor impairment in the child with spina bifida that determines the extent of bowel incontinence. A physical examination and bowel continence history should indicate which management options to initiate. Some patients have reported that diet alone (e.g. roughage and lots of fluid) aid bowel continence and have rejected the recommendations of constant medication (see Table 1).¹⁷

Laxatives, enemas and digital disimpaction may all be employed, singly or concurrently as necessary. An often overlooked part of a bowel regimen is the importance of complete bowel cleansing with enemas prior to exploring a routine of management. Bowel habits have to be the guide to a bowel routine that works. We have found that after an initial thorough cleansing, a combination of glycerine suppositories and a multi-purpose laxative is often satisfactory.

Nurses should make sure, though, that their instructions are fully understood. Just recently, we discovered that one of our mothers for several years had not been inserting suppositories past the internal sphincter. Nor had she realized that they should not be expelled immediately.

The primary objectives of management for most children are avoidance of constipation, social continence and development of a routine that suits the lifestyle of the child and family.

Mobility

One of the questions most frequently asked by parents attending one of our orthopedic clinics is "when will my child walk?" or "will he ever be able to walk on his own?" While walking is a problem that *parents* focus on, *handicapped adults* have rated it as having far less priority than communication or independent living skills.

An important aspect of mobility options is the opportunity they provide for changing sensory input, facilitating eye contact with peers and self-care activities like bathing or eating. Thus mobility is, most importantly, not an end in itself, but a means.

Since experiences at every stage in the life process have an impact on the developing child, efforts are made to simulate "normal" posture and movement during the spina bifida child's early years. In order to accomplish this goal many children, but especially those with more severe involvement, require a "wardrobe" of devices.

During the first six to eight months of life an *infant seat* may be used to assist infants to view their world. Infants with poor innervation and muscle tonus of their backs may have a special seat designed to give them some support. Toddlers who have not developed sufficient back control to sit independently may be able to sit in a *sitting brace* or jacket. With these devices small hands are freed for bilateral functional activities like playing and exploring rather than being used to balance the trunk.¹⁹ A *castor cart*²⁰ can permit toddlers to move independently in play as "normal" children would in crawling. (Figure 4)

Children with spina bifida who are paralyzed or unable to bear weight independently can be introduced to the vertical plane by means of the *standing brace* or *parapodium*. These devices allow exploration of the world during crutchless standing (e.g. touching door knobs, sinks, table tops, etc.) and promote interaction with peers. Crutchless mobility is possible by shifting the center of gravity from side to side in the standing brace and by pivoting on a swivel walker platform added to the footplate of the parapodium. Crutches

may also be used with these mobility devices to allow a swing-through gait. When the children are a little older they can use a manual or powered wheelchair, but in the meantime they will not have been denied the opportunity of standing during the influential early years.

The physiological advantages of the standing position include stimulation of bone growth, reduction in osteoporosis, control of contractures, facilitation of kidney drainage, promotion of good respiratory status, and stimulation of the cardiovascular system.

Body image and sexuality

Developing a good self-image and a positive feeling about one's own sexuality is not one of life's easy tasks. For the child with spina bifida, the process is made more difficult by the physical problems he faces. At our center we have been developing an educational approach to this problem based on the philosophy that sexuality is composed of the way we feel about ourselves and our bodies and the way we share our thoughts and feelings. According to this concept, physical aspects of sexuality like touching, petting and intercourse are only part of the total picture.



4



5

In infancy and early childhood the necessity of awkward bracing and immobility may interfere with spontaneous touching, hugging and exploration. Bowel and bladder problems often require young children to think of their genitals as "public property" as nurses, urologists, therapists all attempt to find appropriate management options. Diminished skin sensation may result in costly pressure sores that immobilize the child further and do not enhance what already may be a fragile body image. The cycles of

hospital and clinic visits, architectural barriers, school absenteeism and social isolation that are part of life for these children, all contribute to a disadvantage in developing self-confidence and social skills.

In the teen years, milestones in growing up, such as group outings, privacy, dating, learning to drive, learning to make decisions, etc. all require major effort for the child with spina bifida.

In terms of sexual gratification in the genital area, each female with spina bifida has her own individual level of sensory impairment. Women, handicapped or not, also vary in their sexual response cycle, some experiencing intense genital sensation and others experiencing more generalized feelings. Sexual response seems to be a combination of innate need and learned response.

Her handicap does not prevent the spina bifida female from conceiving but decreased or absent sensation in the pelvic area, may mean that she will not feel labor pains. During childbirth, she may require assistance with some aspects of labor (for example, pushing with contractions).²¹

Males with spina bifida may have small testicles and/or a small penis and are usually sterile. The capacity for erection and ejaculation will depend on the level of lesion and the extent of nerve damage. Physical examination and history taking will usually identify whether the male has erections and whether they occur with physical or mental stimulation.²² There are usually varying degrees of sensory loss in the rectal and scrotal areas.

To sum up, both male and female individuals with spina bifida need assistance in reviewing sexuality as a broad human experience, not as an isolated genital experience. Feelings of self-worth and a positive body image must be nurtured from birth, in order to de-emphasize "what is wrong" and to build on "what is right."

Community resources

The spina bifida child and his family can profit greatly from a variety of management programs provided by knowledgeable professionals in the community. These multi-disciplinary programs offer information and support for the parents and also provide members of the health team with the opportunity to assess and meet the needs of the child as he grows and develops. Some of these programs are:

Newborn-Nursery Programs provide information on the medical condition of spina bifida for the new parents — the how, what, when and why. Practical teaching sessions should include bladder and bowel management, the signs and

symptoms of blocked shunts, stretchings, handling and general health care. Parents should also have an opportunity to meet other new parents and discuss their concerns.

Multi-Disciplinary Clinics provide an avenue for coordinated care. This usually means only one clinic visit for the family instead of three or four. If the clinic is held in a rehabilitation setting, allied health services are available for the family and clinicians. Pre-clinical assessments establish the current needs of the child and family and usually provide a relaxed, unhurried atmosphere in which the parents may voice their concerns.

Pre-School Programs provide an opportunity for the children to interact with their peers and encourage them in an attitude of independence in play and self-help. They guide the parents with information about child development and provide further medical facts about their child's condition. These programs may also bridge any gap between home and school and allow staff to supervise the orthotic needs of the child.

Parents should be encouraged to explore schooling options early for their child. The elimination of architectural and psychological barriers may take some time, but may be facilitated by public education.

Summer Camps for pre-teen and teenage children can be aimed at teaching further skills contributing to independence in activities of daily living and community living. The children may learn about their own conditions and an avenue is provided for discussion of their own concerns and fears. 4

Co-authors Judith M. Hendry and Norma Geddes have worked together for several years in the promotion of health of children with spina bifida.

Judith Hendry, who was also the author of "Peter: an infant with myelomeningocele," (*The Canadian Nurse*, January, 1977) is an assistant professor in the Faculty of Nursing at the University of Toronto. A graduate of the Hospital for Sick Children in Toronto, Hendry received her B.Sc.N. from the University of Toronto and her M.Sc.N. from the University of Western Ontario.

Co-author Norma Geddes' biographical note appears at the conclusion of her article, "Intermittent Catheterization."

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Agencies that promote care for the disabled

FEDERAL

Canadian Rehabilitation Council for the Disabled

A federation of agencies concerned with services to physically disabled Canadians through fund raising, public education and coordination.

PROVINCIAL

Federation for the Physically Handicapped

Serves as the united voice for provincial organizations for the physically handicapped (e.g. Spina Bifida Associations) and presents briefs to the Government.

Society for Crippled Children (and Adults **)*

Serves children and adults whose activities are restricted by physical handicaps. Services vary from province to province and may include research, district nursing services (Ontario only), summer camps, transportation assistance, traveling clinics, parent counseling, etc.

* Ontario, Quebec, British Columbia

** Saskatchewan, Newfoundland, Manitoba.

Provincial chapters of Canadian Rehabilitation Council for the Disabled

These are located in New Brunswick, Nova Scotia and Alberta and serve much the same function as the "societies" in other provinces.

Spina Bifida & Hydrocephalus Associations

Promote the welfare and well being of persons with spina bifida and/or hydrocephalus. Stimulate public interest by dissemination of literature. (Ontario, British Columbia and Quebec, plus numerous smaller parent groups scattered across the country).

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Intermittent catheterization for patients with spina bifida



Intermittent catheterization is becoming recognized as a successful management option for those with a neurogenic bladder. Its benefits include minimizing the risk of urinary tract infections and enhanced social independence for the individual. As nurses, we are most likely to be involved in teaching the procedure, so we must know how to do it, the rationale behind it, and what patients need to know about it.

Norma Geddes

Urinary incontinence is one of many problems faced by the child or adult with spina bifida. The social problems may well be secondary to the potential danger of renal complications, but it is the social problems that mean so much in terms of daily frustrations and embarrassment — at school, or in the playground.

The adolescent years can be especially traumatic if a satisfactory bladder regimen has not been established. "Growing up" can be stressful in itself, without the additional worry of urinary incontinence. One adult with spina bifida told me that she grew up thinking that if she ever married, she would have to sleep in a separate bed because of her unpredictable bladder.

Traditional routines have been developed for the bladder management of those with neurogenic bladder. These include manual expression (credé) and external appliances with drainage bags.

Another option now being considered is intermittent catheterization, a procedure that may be done independently or with the help of another individual.

Why?

Incomplete emptying of the bladder causes distention, which in turn results in inadequate circulation to the bladder wall, ureteral reflux and recurrent or chronic urinary tract infection. These are factors that predispose the patient with a neurogenic bladder to serious kidney problems. The use of the technique of intermittent catheterization helps to keep the bladder small and undistended and ensures that residual urine does not accumulate. There are good solid studies that indicate that a regimen of intermittent catheterization has improved or corrected urinary reflux and chronic urinary infections.^{1,2}

Certain urologists prefer that the bladder never contain more than 300 cc of urine at any time, necessitating "around-the-clock" emptying at three to four hour intervals, and control of fluid intake. Other urologists recommend catheterization every three to four hours in the daytime only.

Nurses have long been taught strict aseptic technique in the procedure of catheterization. In the case of intermittent catheterization, the patient is taught a clean, non-sterile procedure. In order for the nurse to be comfortable in carrying out or teaching intermittent catheterization, she must understand the rationale behind this departure from the traditional approach.

Advocates of the procedure believe that the bladder wall is more likely to become infected if it is thin and poorly nourished due to overdistention and urinary retention. Keeping the bladder small by draining it regularly through intermittent catheterization helps to preserve the integrity of the renal system.

A teaching program

There are approximately 736 children and young adults with spina bifida on the current active list of the Ontario Society for Crippled Children, and 275 of these patients are seen at regular intervals in the Combined Spina Bifida Clinic. More than one third of these individuals are currently being assessed on a regimen of intermittent catheterization. (See Figure 1)

Patients are referred on an out-patient basis by the clinic to a nursing staff member of the Ontario Crippled Children's Centre. The nurse meets the patient and/or his parents for half an hour or an hour.

We have found that it is important to review with the patient and/or his parents the reason for this procedure —

how it will benefit the patient. Although the urologist has usually covered this information in the clinic, it is our experience that it is rarely retained. Sometimes it is beneficial to have parents watch the nurse perform catheterization; in other cases more successful teaching is accomplished if the nurse gives verbal instructions while the patient or his parents attempt the procedure. There seems to be a psychological advantage when the patient or his parents *do* the procedure rather than merely observing. A nurse will almost always make it appear effortless.

If the family has driven a long distance for this instruction and further reassurance is indicated, we have found it helpful for them to wait an hour or so and practice the procedure again before they leave the Ontario Crippled Children's Centre. Additional reassurance is accomplished through a careful review of the home instruction sheet (See Figure 2) and the telephone number of a resource person.

There are occasions when the out-patient approach is unsatisfactory, when admission to hospital is necessary to give the child time to learn intermittent self-catheterization. This approach may be necessary when

- the child has learning difficulties and initially requires constant supervision;
- the distance between the child's home and the Ontario Crippled Children's Centre is considerable;
- the child requires admission for regular bladder assessment.

Patients need to know ...

When intermittent catheterization is begun, there may be some irritation causing bleeding into the urine or on the catheter. If parents or patients have not been warned of this possibility, they may be afraid that they are doing something wrong. They should be told that initial bleeding should clear up in about a week.

Both patients and parents need to be familiar too with the early signs of urinary tract infections, signs such as:

- fever
- irritability
- cloudy, foul-smelling, or concentrated urine
- a burning sensation on voiding.

It is most important that they also be aware of the fact that significant urinary infection is often asymptomatic. This fact must receive strong emphasis so that the family will not neglect regular culture of the child's urine at local or provincial laboratory facilities. ▸

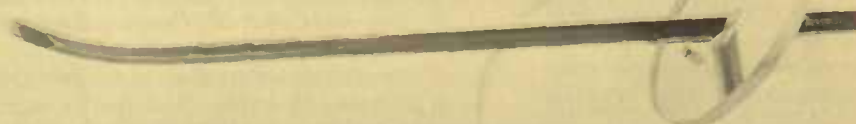


Figure 1

Managing Urinary Incontinence in Patients with Spina Bifida*

Intermittent Catheterization for patients with Spina Bifida	105
No Specific Management (Incontinent)	63
Bladder Expression	51
No Specific Management (Continent)	37
Ileal Conduit	7
Artificial Sphincter	3
Glans Condom	3
No Recorded Management	3
Cutaneous Vesicostomy	2
Perineal Urethrostomy	1
TOTAL	275

* Patients seen in the Combined Spina Bifida Clinic at the Ontario Crippled Children's Centre (reviewed December, 1977).



Social benefits

During the summer of 1976 a four-year-old girl was admitted to our center to be taught intermittent self-catheterization. After using this procedure for a few days, the nurses at the center were prepared to recommend that the doctor try another approach since catheterization failed to keep the girl completely dry. However, when the child's parents arrived for a weekend visit, they told the nurse how pleased they were with their daughter's progress — she was only damp, not completely soaking all the time. This family gave the nursing staff an opportunity to measure success from the patient's point of view.

Intermittent catheterization simulates a more socially acceptable routine of bladder management. If the patient has good sitting balance and manual dexterity, he can sit on the toilet and complete the procedure independently, using only a small catheter and a mirror. (Obviously a mirror is unnecessary for male patients). Bulky diapers can be replaced with mini-pads or sanitary napkins. A protective "panty covering" of light plastic with velcro fasteners can help children conceal their toileting differences.

In addition to the important advantage of enhanced social independence, intermittent catheterization avoids or decreases the occurrence of urinary reflux, and thus of chronic or recurrent urinary infections. ♣

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Figure 2

INTERMITTENT CATHETERIZATION

HOME PROGRAM INSTRUCTIONS*

The frequency of catheterization will be decided by the Ward Doctor or Consulting Urologist.

If you have any questions, please do not hesitate to contact the Nursing Education Office. (telephone number)

Additional equipment information from the Nursing Education Office of the Ontario Crippled Children's Centre.

How to Catheterize

A metal catheter is used with females, a red rubber catheter with males.

1. Wash your hands with soap and water.
2. Wash the perineal area with warm water.
3. Have a container available to collect the urine, e.g., flat pan; if possible the child should sit on the toilet.
4. Rinse the catheter under warm water.
5. Lubricate the catheter if necessary (use a lubricant that dissolves in water — do not use vaseline).
6. Insert the catheter about 1" to 1½". Catheter is inserted 1" to 1½" plus the distance of the penile urethra for a male.
7. Let all the urine drain out.
8. If you insert the catheter into the vagina, rinse under warm water and start again.

Care of Catheter

- wash catheter with soap and water after use; rinse well.
- boil catheter once a week for a few minutes.
- between catheterizations, the catheter can be kept in a clean, dry, container.

Outings

- keep the catheter in a clean container or wrapping.

* Ontario Crippled Children's Centre

Author Norma Geddes spent the years between 1972 and 1978 as Inservice Education Coordinator at the Ontario Crippled Children's Centre in Toronto, Ontario. She has recently joined the nursing department of the University of Virginia Hospital, Charlottesville, Virginia.



Antepartal fetal monitoring: *the nurse's role*

Edris A. Sandy

Many obstetrical patients, especially those who have been designated as 'high risk', may have reduced uteroplacental function. The diabetic, the pre-eclamptic, chronic hypertensive or any obstetrical patient with vascular impairment carries a fetus at increased risk of intrauterine hypoxia especially during labor.

In the last fifteen years, electronic fetal heart monitoring has come to be an accepted part of fetal surveillance during labor. More recently however, it has been recognized that monitoring the fetal heart long before labor begins — in the antepartum period, during the latter part of the third trimester — can be an effective tool in testing the degree of uteroplacental insufficiency. Results of this early monitoring can indicate to the health team how the fetus will react during labor and therefore aids them in decisions regarding the most appropriate timing and mode of delivery (*see figure 1*).

Currently, there are two tests being done that involve antepartum fetal heart monitoring. The Oxytocin Challenge Test (Oxytocin Stress Test, Contraction Stress Test) is a non-invasive measure of the fetal heart response to oxytocin — induced contractions. The purpose of the test is to identify cases of reduced uteroplacental function in which even mild uterine contractions may cause hypoxia and late deceleration of the fetal heart. The second test, the Non-stressed Test, measures the variability of the baseline fetal heart and determines the presence or absence of fetal heart accelerations during fetal movement or spontaneously occurring uterine contractions.

At the Women's Centre at the Health Sciences Centre in Winnipeg, 800 oxytocin challenge tests have been performed on 500 patients over the last four years. It is the purpose of this paper to outline the practical aspects of antepartum fetal monitoring and the role you as a nurse can play in this procedure.

Indications

Antepartum fetal heart assessment is indicated in any case where there is reason to suspect the adequacy of placental function. In our experience, the most common indications for the test have been:

- hypertensive disorders (47 per cent)
- small for dates (15 per cent)
- diabetes mellitus or gestational diabetes (13 per cent)
- prolonged pregnancy (12 per cent)

The period of gestation when antepartum testing should be started will depend on how early in the pregnancy the problem is recognized, but it should not be done until the fetus is potentially viable and one is willing to act on the result. Thus, testing is rarely started before 32 weeks gestation.

Contraindications

The test is contraindicated in cases of threatened premature labor, premature rupture of the membranes, suspected placenta praevia, previous classical caesarean section, hysterotomy or for any other case in which uterine

contractions are undesirable. A previous lower segment caesarean section or grand multiparity are not necessarily contraindications, but obviously the test must be carried out judiciously, recognizing the risks involved for these patients.

For those patients in whom oxytocin-induced contractions are contraindicated, the non stress baseline fetal heart assessment can be performed alone.

Patient Preparation

As with all tests, particularly those involving rather formidable looking electronic equipment, adequate patient preparation is vital. We have found that it is most advantageous if the patient's doctor outlines the test and its rationale. This, plus a brief pre-test visit by the nurse who will perform the test, almost always results in a calm, cooperative patient.

During the pre-test visit, briefly review the patient's history with her and the reason why she has been admitted for the test. Outline what is involved in the

Figure 1

What happens during reduced uteroplacental function:

- The placental circulation carries oxygen and simple nutrients to the fetus.
- Decreased placental perfusion that occurs in obstetrical patients with chronic vascular impairment often results in a decrease in available oxygen to the fetus.
- When the uterus contracts, the placental blood flow is temporarily reduced and the fetus uses the placental reserve to sustain him until the contraction stops. However, an "at risk" patient often has a placenta whose reserves are compromised.
- The contractions, whether spontaneous or induced, result in decreased blood flow and may not be adequate to meet the oxygen needs of the fetus resulting in late deceleration of the fetal heart.

Figure 2**Classification of test results used at Women's Centre, Health Sciences Centre, Winnipeg, Manitoba.**

A normal "active" baseline recording (non stress test) should show normal variability of the fetal heart (> 5 beats per minute), and accelerations (> 10 beats per minute) when associated with fetal activity. This indicates an excellent prognosis for the fetus.

A negative OCT shows a normal baseline and no decelerations of the fetal heart. In addition, those tests which show early or intermittent variable decelerations are classified as negative.

A positive OCT is characterized by repeated, consecutive, late decelerations.

A suspicious OCT is one with any of the following patterns: lack of accelerations (< 10 beats per minute) associated with fetal movements; persistent baseline tachycardia (> 160 beats per minute), bradycardia (< 120 beats per minute) or reduced variability (< 5 beats per minute); repeated, consecutive variable decelerations or intermittent late decelerations.

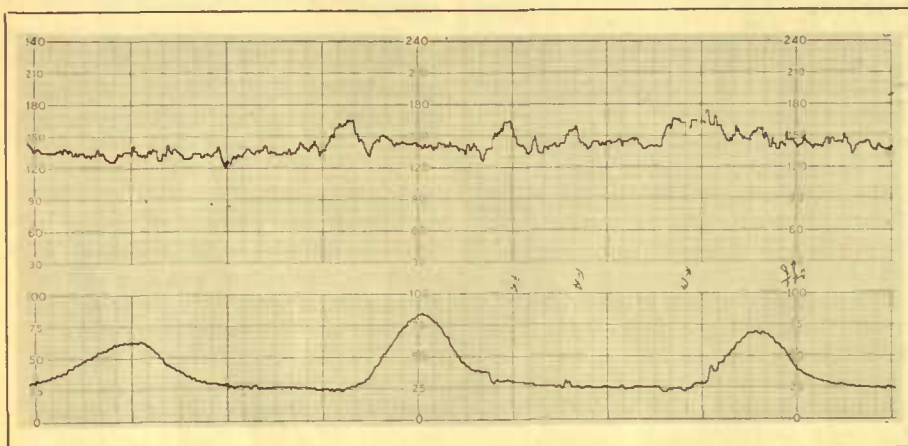


FIGURE 2(a)
Negative OCT — Normal baseline rate and variability. Accelerations associated with fetal activity (FA). No decelerations.



FIGURE 2(b)
Positive OCT — Repeated late decelerations

test, its rationale and its relationship to other tests she may have during her admission. This helps to reinforce what she has already been told, and in some instances is an opportunity for you to correct any misconceptions she may have. Try to anticipate and answer the more obvious patient concerns about the test — the most common being whether the test will harm the baby or that it might start labor prematurely.

Many patients are anxious to know what the result of the test will hold for them. It is important to emphasize that this is only one test of the baby's health, and that the result will be taken in conjunction with the results of other tests and clinical observation. These will help the doctor to plan the best management to ensure a good outcome for this pregnancy.

During the actual test, it is important to explain what you are doing when setting up the monitor, increase the volume of the ultrasound transducer and get an audible fetal heartbeat for the mother to hear. We have found this to be very reassuring for the patient. At this time, the nurse has a great opportunity for patient teaching, not only of fetal heart monitoring, but of all phases of antepartum and intrapartum care. Over the past four years, we have observed that patients who have had antepartum monitoring are well prepared for and expect intrapartum monitoring.

Equipment

The fetal heart may be monitored by any of the three external methods (ultrasound, phonocardiography, and external ECG). It is important to note that none of these methods will accurately represent beat to beat variability. Ultrasound is the least reliable in this respect and may show apparent variability where none exists. However, it has the advantage of producing a clean and interpretable tracing in over 95% of cases. Phonocardiography may give a closer representation of baseline variability but will fail to give a clean tracing in 10-20% of cases during contractions. A reasonable compromise is to use phonocardiography for a baseline recording and then switch to ultrasound should the tracing be unsatisfactory during contractions. Our experience with external ECG is limited but this may prove to be the best method.

Uterine activity is recorded using an external tocotransducer. The oxytocin is given by a constant infusion pump.

Procedure

The test is best performed in the relative calm of the antenatal ward or in a quiet room adjacent to the labor floor. The patient is placed in the semirecumbent position and the blood pressure taken every 10 minutes to detect supine

hypotension. In this position, supine hypotension occurred in only 2.7% of our cases. Ideally, the patient should be in the lateral position to avoid aorto-caval compression, but in practice it is hard to get a good tracing with external monitoring with the patient in this position. A pillow under one hip may help to displace the uterus and reduce the chance of aorto-caval compression.

The non-stress test that records the baseline fetal heart usually takes 20-30 minutes to complete. If the oxytocin challenge test (OCT) is also done, an intravenous oxytocin infusion of 0.5 milliunits/minute is started after the 20 minute baseline recording. The dosage is doubled every 15 minutes until contractions are occurring every 3-4 minutes. The response of the fetal heart is then observed over 10 contractions or over 3 contractions during a 10-minute interval. In some cases (7% in our series), the oxytocin infusion is unnecessary if the patient is having adequate numbers of Braxton-Hicks contractions. This is more likely to occur if the test is performed shortly after an amniocentesis, a practical point in those cases where oxytocin is contraindicated. Generally, a complete OCT takes an average of 2 hours.

In a number of cases, an unclear tracing or an inconsistent pattern (eg. intermittent late decelerations) may be obtained. However, in such cases it is worth continuing with the test. Usually after re-positioning the patient, an interpretable tracing can be achieved and the inconsistent pattern is clarified.

Complications

The most serious complications of the oxytocin challenge test are rupture of the membranes and premature labor. In practice, these have not been a problem in any of the reported series,¹⁻⁴ and in our experience at the Women's Centre, this complication has occurred in less than two percent of cases, within 24 hours of the test. In all cases, the patients were beyond 37 weeks gestation. At this stage, it is difficult to tell whether this was a coincidence or a direct complication of the test.

Another complication that may arise if the oxytocin dosage is increased too rapidly is uterine hypertonus (contractions lasting 2 minutes or longer, or occurring less than two minutes apart). This was a problem in 5 per cent of our patients. If this happens, discontinue the oxytocin infusion, wait a few minutes, and then resume the test with a decreased oxytocin dose.

Interpretation of results (see figure 2)

A negative OCT is a reliable indicator that the fetus will survive another week in utero. It must be remembered, that there is a false negative result in about 2 per cent of women taking the test.

Therefore, it is usual to repeat the test on a weekly basis in patients with a negative result.

A negative OCT does not preclude the development of fetal distress in labor, however. Repeated late decelerations occur in 3-10 per cent of patients in the subsequent labor.

The significance of a *suspicious OCT* is not entirely clear. In a number of series, patients, with this result, had similar outcomes compared to those with a negative test. Those women whose tests indicate reduced variability, intermittent late decelerations or repeated variable decelerations should be watched carefully. Taken in association with other factors, a suspicious test may swing the balance in favor of early delivery. If not, the test should be repeated in 24-48 hours.

A *positive OCT*, characterized by repeated, consecutive late decelerations, is usually associated with a poor perinatal outcome. However, there is a high incidence (20-40 per cent) of false positive results with the fetus tolerating subsequent labor well. Certain characteristics may help to distinguish the true from the false positive OCT:

- If the tracings show that late decelerations disappear when the patient moves onto her side, the test is likely to be false positive. This may be due to aorto-caval compression where there can be a decreased uterine blood flow.
- If the baseline fetal heart rate shows good variability and acceleration with fetal activity, the test is more likely to be false positive.

If the non-stress baseline fetal heart rate is normal, there is only a remote chance that the OCT will be positive. In many hospitals, the baseline rate is now used as a screening test and the complete OCT is performed only if the fetal heart rate variability is reduced or if there are no accelerations on the baseline tracings. In case where the non-stress test shows these abnormalities, physically stimulating the fetus by palpation of the mother's abdomen may revert an abnormal baseline to a normal one.

If, however, the baseline remains abnormal, then the full oxytocin challenge test should be performed. Some studies have shown that four out of five patients will not require the OCT if this protocol is followed.

Conclusion

In recent years, increasing attention has been paid to the value of antepartum fetal monitoring in the management of high risk pregnancies. Nurses are playing an increasing role in this field, not only in the administration of the tests but also in their interpretation. In addition, it offers the nurse a major opportunity for patient education in many aspects of obstetrical care. ♀

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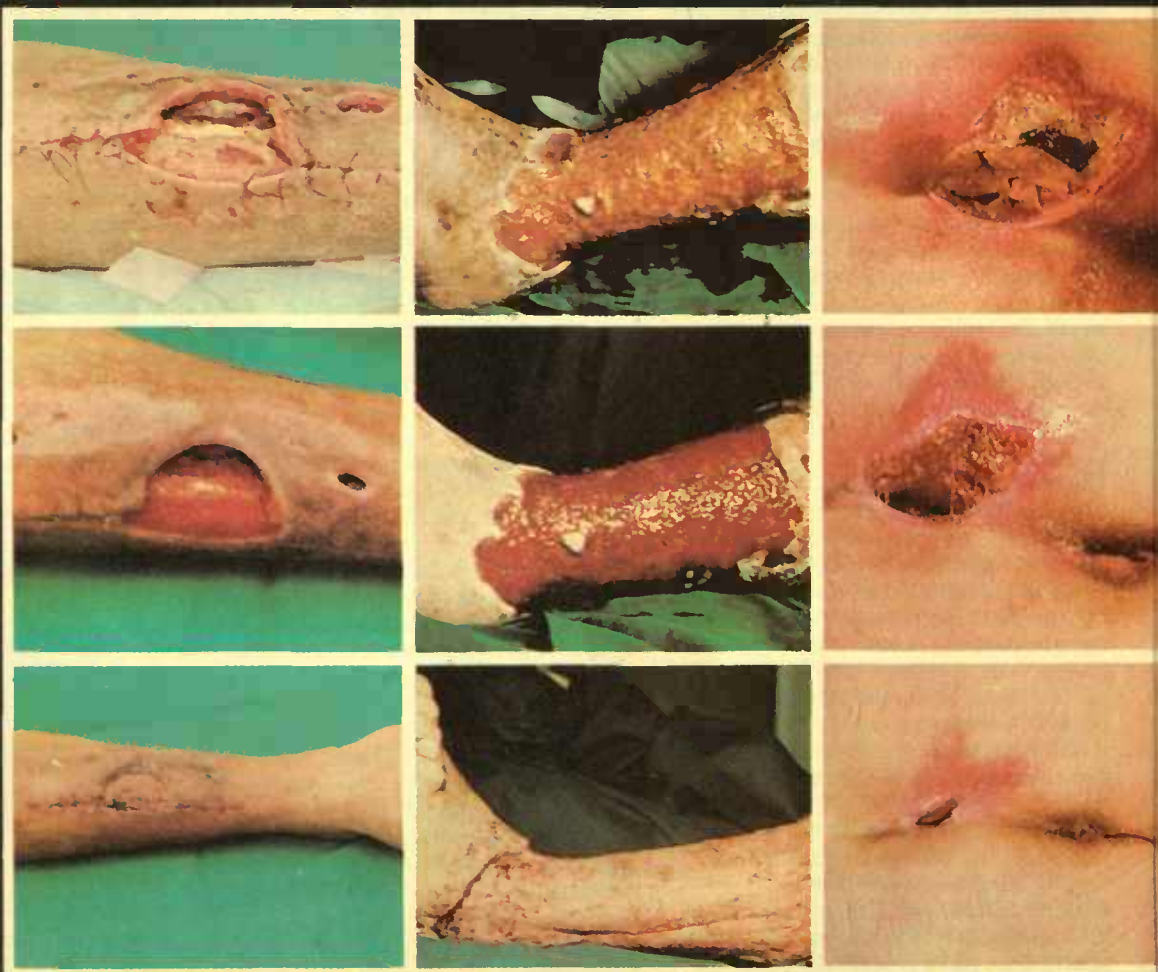
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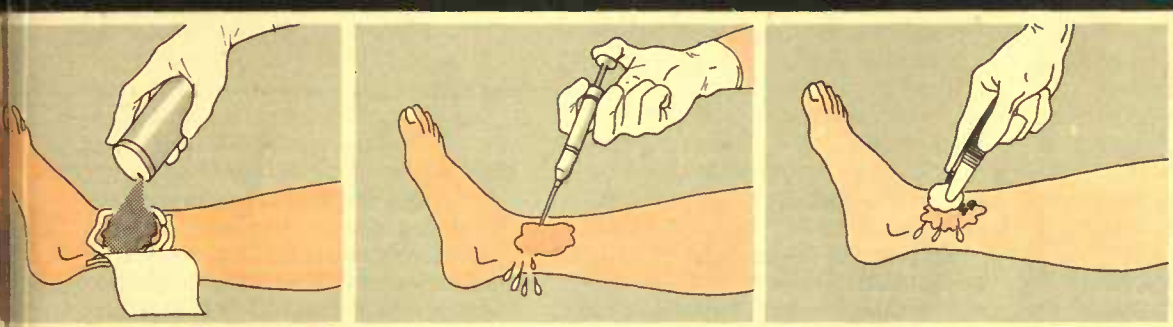
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1. An 83 year old male with a decubitus ulcer showing a heavy growth of *Proteus mirabilis* resistant to penicillin G and V, erythromycin and doxycycline.
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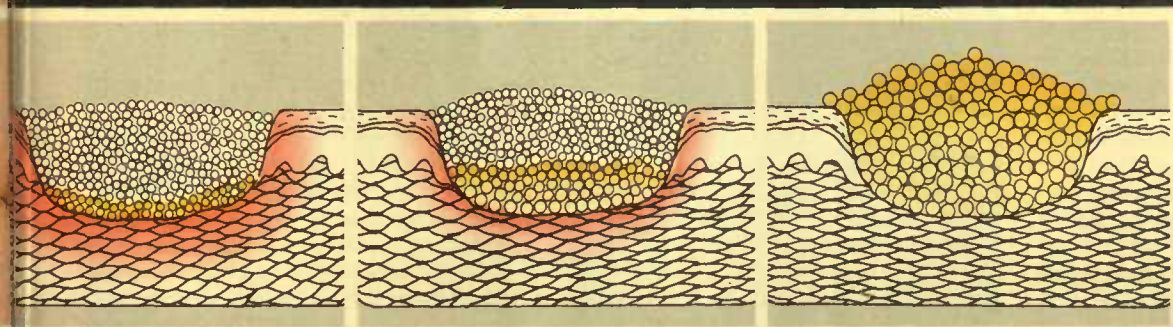
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1. Data on file at Pharmacia (Canada) Ltd.
2. S. Jacobsson et al., Scand J Plast Reconstr Surg 10:65-72, 1976.
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Last June, more than 1000 nurses climbed aboard planes in various centers across Canada to begin the long journey that would take them across the Pacific Ocean and back. Altogether they spent close to three weeks out of the country, most of it in Japan where they joined 11,000 of their counterparts from around the world for the 16th quadrennial congress of the International Council of Nurses. That trip was a once-in-a-lifetime event for almost everyone who went on it but, for one of the Canadian nurses, it included an unexpected experience that has added a new dimension to the caring quality of her life and work since then.

ARIGATO, Japan

Hazel Schattschneider

I knew when I booked my seat on the ICN tour to Tokyo, Japan, in late May last year, that my decision involved an element of risk. Risk, however, was something I had learned to live with in the four years since doctors had diagnosed my "dizzy spells" as stemming from stenosis of the aqueduct of Sylvius — a narrowing of the duct between the third and fourth ventricles of the brain resulting in hydrocephalus which necessitated the insertion of a VA shunt.

Let me begin at the beginning. In the summer of 1973, I began having dizzy spells which increased in frequency and at times seemed almost like seizures. I attempted to deny the possibility that these could be caused by anything more serious than overwork but when my family became aware of my secret, I sought medical attention.

A neurological examination which included a skull Xray, revealed an abnormality in the area of the pituitary gland. I was admitted to hospital for Xrays and tests.

An angiogram showed an elevation of the blood vessels suggesting an enlargement of the ventricles and subsequent ventriculogram confirmed the diagnosis of stenosis of the aqueduct of Sylvius.

This condition is reviewed in a paper¹ which my surgeon co-authored. The paper reviews nine cases of aqueduct stenosis treated in Edmonton, discusses the various ways in which it presents and concludes that the etiology remains unknown. I considered myself lucky, however, to have the benefit of

even this much knowledge and experience.

Treatment for aqueduct stenosis consisted of the insertion of a ventriculoatrial shunt. Explanation of my diagnosis and the surgical procedure was given to me by my doctors. An article which the head nurse shared with me describing a case of adult hydrocephalus and the surgical procedure², also helped me to understand what was happening.

The procedure involves the insertion of a catheter in the right lateral ventricle of the brain through a burr hole. The catheter is attached to a valve located subcutaneously behind the ear. The atrial end of the catheter is inserted into the jugular vein to the atrium of the heart.

My post-operative course was uncomplicated and soon I resumed normal activity. I was aware of the possibility that the shunt could block; my physician had warned me that a severe early morning headache could be a warning sign of problems.

Less than a year after my original surgery, my shunt did block with effects similar to the ones I had been warned about. My shunt was revised and after a period of recuperation, I returned to work and normal activity.

After that experience, the possibility of recurring problems was very real but something I came to accept. While recognizing the importance of taking appropriate precautions, I developed the philosophy of living one day at a time and making the most of opportunities as they presented themselves.

That's why it was natural and not surprising for me to respond to the opportunity presented by the ICN Tour to Tokyo, Japan, for the International Congress of Nurses. When I left it was with a sense of awe at the distance I was travelling and excitement about what I was about to see and to experience in the Orient while attending an international gathering of my colleagues. I was aware of the risks but knew I would be travelling with other nurses and I felt I would not be alone. I was right — I was not alone, although I would have preferred not to put it to the test.

On the third day after our arrival in Tokyo, while on a sight-seeing tour, without any more warning than a vague headache which seemed natural after a long journey across the Pacific, I gradually lost awareness and control. At the end of the tour, I lost my way and missed our sight-seeing bus. When I was missed, the bus returned for me. I was assisted to my room in the hotel. When my friends found me some time later — in a coma — with tremors they arranged to have me taken to St. Luke's International Hospital where there is a neurosurgeon on staff. The doctors who examined me put together a medical history with the help of my colleagues and then contacted my family in Canada. Within hours, my second shunt revision was underway.

This time my ventriculoatrial shunt was replaced with a ventriculoperitoneal shunt. Current knowledge indicates that the VP shunt is one of choice over the VA shunt primarily due to its lower rate of complications³. When I returned to

Canada I learned that my physicians there were using the same technique.

So, thirty-six hours after participating in my first Japanese tea ceremony, I awoke to hear someone telling me that I was in a hospital in Japan, that my shunt had blocked, that I had had surgery and that my family knew and were sending a friend to be with me.

Was it real? Had this really happened to me? Was I actually in Japan... so far from home, family and friends? But I certainly wasn't alone! When I regained consciousness I began to realize how much anxiety I had caused so many people. Messages and visitors, flowers and cards began to arrive. My Canadian colleagues kept the hospital switchboard busy with their inquiries. The Japanese people themselves offered care and support in their own gracious manner. First the travel agent, and then the Canadian Embassy were informed of the "Canadian in distress" and became involved in my care.

How fortunate I was to have a doctor who spoke English and welcomed the chance to practice it. Nurses who spoke English were assigned to my care. What could have been a very frightening situation was one in which I felt secure and cared for.

Still I couldn't believe that all of this had really happened until the arrival of my friend from Canada helped me to face the facts of the situation. She was my contact with reality; with her help I sorted out the sequence of time and place and past events. She helped me deal with the question "why?" and thus begin to accept what had happened.

After two weeks in hospital in Japan, I returned home. My Japanese experience had turned out to be a most unique one in that it permitted me to experience the warmth and care of the Japanese people and culture in a very

special and personal way. At the same time, it was good to be "safe home" again and to begin, gradually, to pick up where I had left off. I am back in the full swing of activity again now. But how do you live with the reality that one day, in a strange place you lost control of your judgement and senses - and the reality that it can happen again?

As an individual who always valued my intellectual ability and independence, loss of control meant accepting the need for intervention by family, friends, medical and nursing personnel. Slowly I began to realize the truth of John Donne's observation that "No man is an island, entire of itself". Living with potential loss of control as I do now also involves acceptance, faith and hope.

I am both thankful for and reassured by continuing research and growing knowledge. Since my original surgery, for example, the EMI scanner and the X-ray technique, Computerized Transaxial Tomography (CAT scan⁴), has become available. This technique can distinguish pathology in the brain and provide information about the changing size of the ventricles, thus identifying problems with a malfunctioning shunt. How much safer and more pleasant than the pneumoencephalogram or ventriculogram! Besides being a most significant advance in neurological diagnosis, the CAT scan has obvious personal implications for me.

As a nurse, I think I can understand people in my care who have lost control a little better now. I've shared a little of that same space with them. I can begin to understand the many losses they experience and their need for support and assistance in dealing with these losses. I know about their unanswered questions and I can understand their desire to maintain or regain control and

independence. I recognize the role of the nurse in providing support for her patients and yet still allowing them to maintain control.

As one who lost touch with but then regained contact with reality, I know how much I depended on those around me to understand, to care and help me regain contact with reality and then to allow me to regain independence and self confidence.

- I know how much I wanted explanations regarding my care and needed reassurance.
 - I know how my family wanted to be informed and involved.
 - I know how I want to be allowed to make decisions for myself.
 - I know how good it feels to regain control and independence.
 - I no longer ask "why?" all this happened but rather "what am I going to do because it happened?"
- That is why I have shared with you. ♡

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When author Hazel Schattschneider wrote "Arigato, (thank you) Japan" she says she intended it as "a way of sharing an experience that I believe has real implications for nurses and for living." She wanted also to communicate with all of her colleagues on that eventful tour and to acknowledge and thank them for their care and concern during her hospitalization.

For the past two years Hazel has worked on a special project as a nursing home consultant employed by the Edmonton and Rural Auxiliary Hospital and Nursing Home District No. 24. A graduate of the University of Alberta Hospital School of Nursing, she has also received diplomas in Outpost Nursing and Public Health Nursing from Dalhousie University, Halifax and her B.Sc. from the University of Alberta. She has worked as a staff nurse in Edmonton and Alaska and as municipal nurse in Fort McMurray, Alberta and Supervisor of Nurses in Vegreville Health Unit, Vegreville, Alberta.



Ten Japanese nurses join the author in posing for a farewell photo as she prepares to leave the hospital after her two-week stay.

A POSITIVE APPROACH TO NEGATIVE BEHAVIOR

How do you see yourself in relation to the aggressive, angry or hostile patient? Do you think of yourself as "the nurse with super control"...non-judgmental, objective, never emotionally involved with your patient? Do you think of the aggressive patient as helpless in the face of his destructive impulses? Attitudes towards disturbed behavior are changing and modern methods of treatment offer advantages to both patients and staff.

"Recognition that patients react to their environment and do have controls, and that staff react to patients, must be a beginning point for intervening in disturbed behavior."

Lillian R. Stegne

Twenty or thirty years ago, advances in chemotherapy and methods of treatment fostered acceptance of the belief that all disturbed behavior was either predictable or preventable. Nurses and other staff were encouraged to regard incidents of violence as isolated instances of treatment failure brought about by an ineffective approach of staff to patient. Today we are just beginning to accept the fact that disturbed behavior on the part of some of our clients is still a fact of life for health professionals.

Violence, or the potential for violence, is still with us — a reality not only for those of us who work in psychiatric hospitals, but also for those who work in general hospitals, corrections, ambulance services, and in special education for the developmentally handicapped. Today, personnel in these settings are becoming increasingly concerned about how effective they are in providing care to the disturbed person. They realize that when they fail two persons suffer — the patient who is exposed to staff who are inadequately prepared to assist him/her when disturbed; and the staff member who is required to provide care he/she was unprepared to give.

In our institution, St. Thomas Psychiatric Hospital, the impetus for development of a program to prevent disturbed behavior and to protect staff and other patients, was provided by several instances of patient and staff injuries. Both senior management and union representatives expressed concern over the number of incidents of disturbed behavior that were occurring. A hospital task force was set up and as a result of the recommendations of this body the staff development department was requested to design and implement a comprehensive program aimed at providing a more therapeutic environment for patients and a safer environment for both staff and patients.

Program development

From the beginning, we recognized that the type of total program we planned would require more than brief educational input and would, in fact, necessitate ongoing review of all disturbed behavior from a variety of aspects. Therefore, a formal system of reporting and accountability was designed to allow for input from staff and patients, including responsibilities of the staff development department, responsibilities of the "committee for the prevention and management of disturbed behavior," accountability of the clinical team, avenues for review available to the patient, and defined hospital policies.

The prevention and management of disturbed behavior

St. Thomas Psychiatric Hospital is a 524-bed treatment facility located in southern Ontario. Three years ago, the 300-member nursing staff, along with other members of the health care team, got together to work out a comprehensive program for the management and treatment of disturbed behavior that they hoped would lead to a safer staff environment and a more humane approach to treatment of the disturbed patient.

The result was a program that has been recognized by the American Psychiatric Association which awarded its originators a gold medal "for significant contribution in the field of mental health." Since the program was implemented at S.T.P.H.:

- incidents of disturbed behavior have decreased by close to 10 per cent
- incidents of patient injuries have decreased by 12 per cent
- the number of patient-related staff injuries have decreased by 10 per cent; and
- hours lost because of injuries have decreased by 31 per cent.

The principles of the program are outlined in a videocassette and workbook, "The Prevention and Management of Disturbed Behavior," prepared by S.T.P.H. staff development coordinator, Lillian Stegne and published by the Ontario Ministry of Health. The following are excerpts from this manual:

"Today's society, which places emphasis on the dignity and rights of the individual, demands that those who work in the service areas of mental health, corrections and retardation, find more suitable means of treatment and service. If the current and future demands for quality care are to be met, it will be necessary for staff to consider not only effective methods of physical restraint, but the entire area of disturbed behavior; that is, causes and prevention prior to any attempt at physical intervention..."

The developmental dynamics of why individuals react negatively to situations cannot be dealt with in our brief presentation. However, we will consider the factors which might precipitate disturbed behavior and the general types of disturbed behavior we might see in hospital...

Staff members, particularly the direct-care staff who are constantly in the patient environment, must be given the opportunity to discuss their philosophies of patient care, their feelings and reactions to aggressive acting-out patients, and their manner of working with very disturbed patients. This analysis must be conducted in a non-threatening, non-punitive environment which will allow free expression of feeling and which will allow staff members to learn and to grow in their ability to work with the hostile patient. In such an environment, staff will learn to analyze how they respond to anger and how they affect the patient, and from this, will be able to modify their behavior so that the ward environment becomes more therapeutic for the patient...

The guidelines were produced by surveying direct-care staff in a psychiatric hospital to determine the most common situations in which they must intervene. A set of guidelines for staff responses was then carefully selected so that these responses are not dependent upon the size or physical strength of either staff or patients. This means that, with appropriate skill training, female staff members may adequately intervene with a male patient. Of course, regardless of the situation, good judgment must be used to determine if assistance is required...

The guidelines for physical intervention are not meant to fulfill all the needs in the management of disturbed behavior. Emphasis should still be placed upon predicting and preventing disturbed behavior, if at all possible. However, for those situations which are not preventable, staff should be assisted in developing the necessary efficiency and competency."

In designing the program, the staff development department placed initial emphasis upon the predictability and preventability of much disturbed behavior. Phase one of the educational program was conducted in a classroom setting, for all staff members, both clinical and non-clinical, and consisted of films, discussions, exercises in communication and role-playing, all directed at stressing the importance of staff in providing a therapeutic milieu to reduce the institutional factors that often precipitate disturbed behavior.

Phase two of the program involved skill-training for efficient and effective physical intervention. Since our search of educational resources did not discover any program for physical intervention which we felt appropriate for a psychiatric setting, we decided to prepare a complete audiovisual package which could be utilized for skill-training. The content of this aspect of the program was identified by interviewing direct-care staff and asking them to describe the most common types of necessary physical intervention. From these responses, a program was developed which included release from wrist grips, release from chokes, use of various body restraints, protection from minor patient aggressions (e.g. biting, kicking, scratching), and finally protection from major patient aggressions (e.g. an armed attack). Once the program had been approved in policy we moved to provide all staff members with a minimum of 10 hours of skill-training under the direction of a qualified instructor.

Implementation

Clearly established hospital policies are necessary for the protection of the hospital as an employing agency, and for the staff member as an employee. Such policies ensure that only approved methods of intervention are acknowledged and administratively supported.

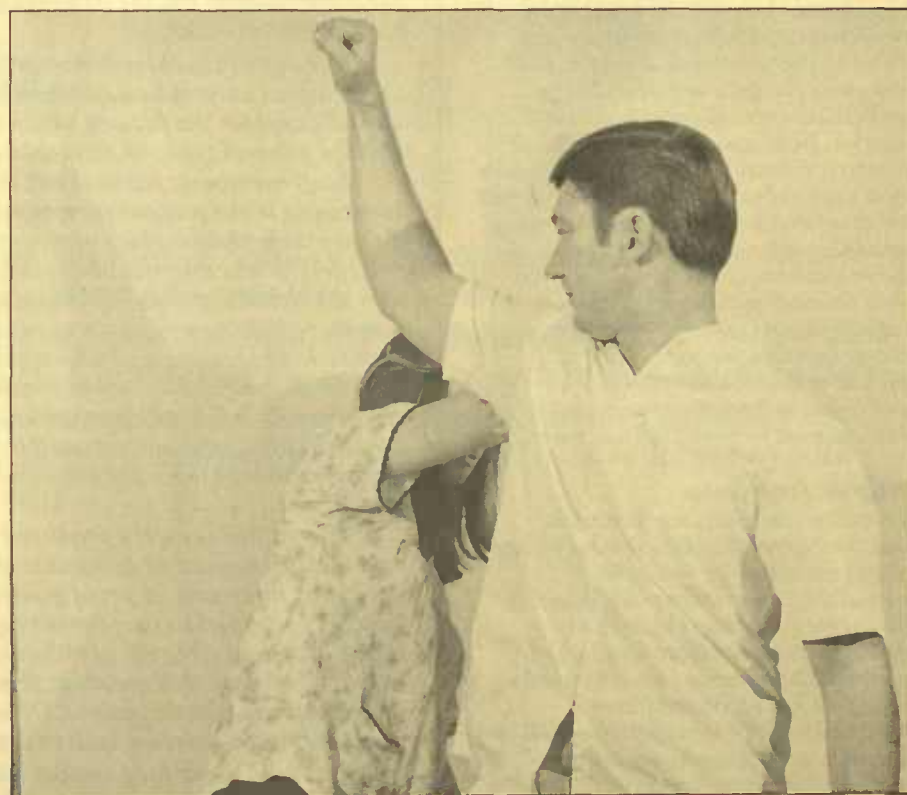
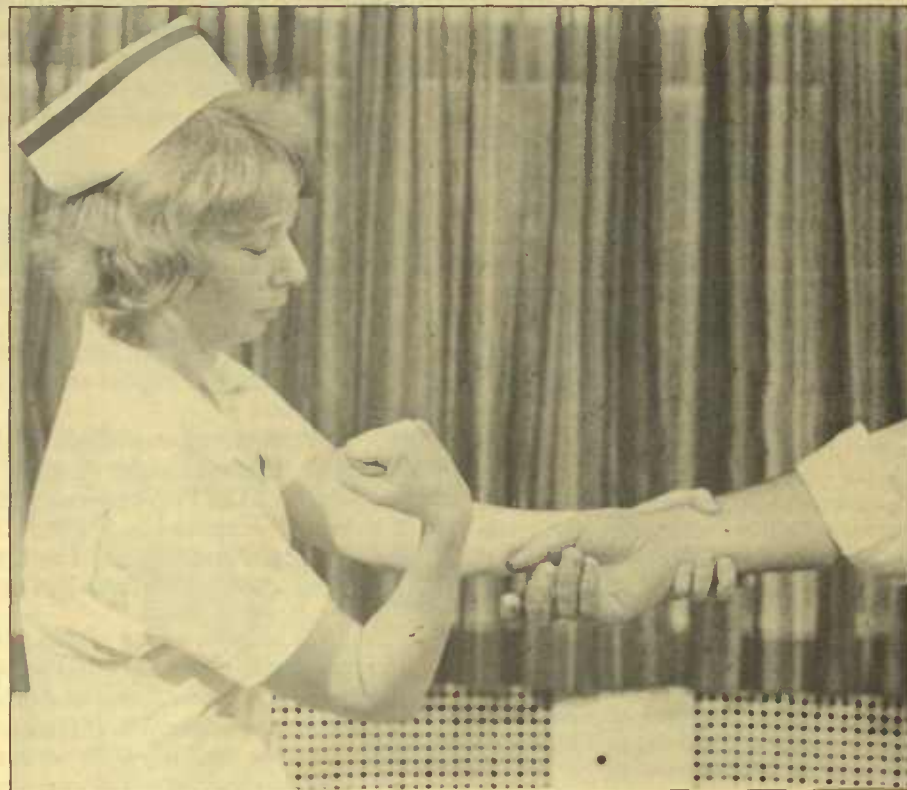
S.T.P.H. policies include statements covering the following:

- in the case of a psychiatric emergency, any staff member in the environment is accountable for providing the required assistance;
- participation in both the initial training program and also in the refresher skill-training program is mandatory for all staff;
- only those methods of physical intervention which have been approved by the professional advisory committee and the administrator are to be used;
- the "trainer" function is part of the work assignment of the staff members selected.

Ongoing review

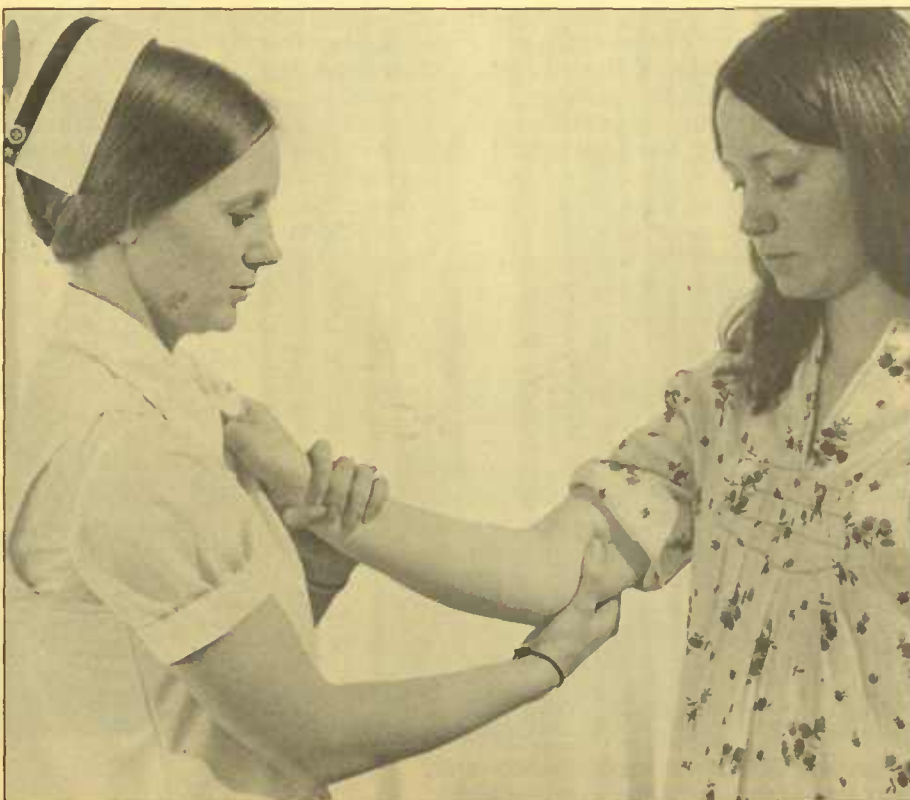
A committee structure organized to

Release from one-hand grip — Both one- and two-hand grips are broken through the weakest part of the grip, between thumb and forefinger. Above, nurse demonstrates how to bend fist toward your own wrist and, with a quick motion, pull your wrist through the thumb and finger of the patient, pulling outward. Other hand remains in place at his wrist throughout the action.



Release from rear choke (standing) — A backstroke swimming action easily releases staff from a rear choke. Above, staff member demonstrates how, using either arm, to move your arm upward and backward in a large arc that will result in grip being broken.

Straight arm lever restraint — *This restraint uses pressure on a patient's arm to cause discomfort, but no injury so that the resistive patient may be moved or lifted. Above, two nurses demonstrate how to apply pressure by pushing down on patient's wrist with hand and up at the elbow with forearm.*



Release from a patient bite or grip on clothing — *Use of body pressure points for release from grips causes discomfort but no injury. Above, nurse shows how to apply pressure with thumb or first finger to inner aspect of patient's elbow so that patient releases grip because of discomfort.*

review all incidents of disturbed behavior, plus staff and patient injuries, can be of great assistance to direct-care staff as well as to the administrator of an agency.

At S.T.P.H., the committee for the prevention and management of disturbed behavior was organized as a sub-committee of the senior hospital committee, the professional advisory committee, which reports directly to the administrator. Committee members therefore have access to the administrator through only one level of committee structure and are able to obtain administrative decisions very quickly. To maintain a close liaison with the hospital safety committee, a member from the committee for the prevention and management of disturbed behavior has been made a member of the safety committee.

Membership on the committee includes representatives from the clinical departments of psychology, medicine, nursing and social work; from staff development; and from the S.T.A.R.T. Centre which is the retardation facility located on the hospital grounds.

The committee meets on a monthly basis or, in case of emergency, upon the call of the chairman. It is responsible for:

- reviewing and analyzing, on a monthly basis, all reports of disturbed behavior;
- requesting to meet with a clinical team to discuss specific areas of concern or designated cases which the committee wishes to review;
- responding to requests from the administrator, medical director and the chairman of the safety committee to review designated cases;
- assisting clinical teams and administration by recommending preventive measures which could include changes in an individual patient's program, or a procedure or policy;
- recommending to the professional advisory committee and the educational advisory committee, educational needs of staff in relation to the area of disturbed behavior;
- approving and recommending procedures and policies reintervention of disturbed behavior to administration for ratification.

Members of the committee strive to establish a climate of helpfulness, rather than fault-finding. The clinical teams that the committee has met with appear to appreciate the fact that the committee is aware of and concerned about their problems; they have been most supportive and cooperative in any review and recommendations arising from the reviews. Because the committee members are not, on the whole, directly involved with the cases being reviewed, they are able to be objective in their analysis and to be of

significant assistance to the team members who may have lost some objectivity because of being too close to the situation.

The Clinical Team

First-line action in the prevention and management of disturbed behavior rests with the clinical team which, at the patient unit level, is accountable for all treatment programming for the individual patient. This team is in the unique position of having first-hand specific information that loses impact when interpreted to those removed from the situation.

The clinical team at S.T.P.H. has been made responsible for:

- structuring individual patient's programs to meet individual needs;
- conducting "psychological autopsies" or reviews of all disturbed behavior, including consideration of causes and preventive measures possible;
- implementing treatment program changes, which will prevent future disturbed behavior for an individual patient;
- implementing changes at the total ward level which will possibly reduce incidents;
- recommending to the administrator through the committee for the prevention and management of disturbed behavior, necessary changes in policy or procedure or a particular system which requires change or modification;
- reporting all incidents of disturbed behavior.

Protecting patient rights

Any treatment program if it is to be effective must provide for input by the consumer, i.e. the patient. Information obtained in this way is used by staff to modify the program in the light of the deficiencies or strengths it reveals. It also provides a means of ensuring that the patient's rights are protected.

Patients at S.T.P.H. have several channels for expressing their comments and criticism. They can, for example, report to their case coordinator, social worker, or doctor. They can record their comments on the disturbed behavior form or they can contact the ombudsman assigned to patients, request legal aid or a board of review hearing, or use any avenues of political and public contact available to citizens of the province.

Staff Development

As staff development coordinator, I am expected to:

- participate as a member of the committee for the prevention and management of disturbed behavior;
- participate on demand as resource person in the clinical team's review of disturbed behavior;
- provide all new staff, within one month of employment, with the total

program of prevention and management of disturbed behavior;

- provide opportunity for all staff to periodically participate in review skill-training sessions;
- respond to requests for staff education from two hospital committees — the education committee and the committee for the prevention and management of disturbed behavior.

Evaluation

Positive feedback regarding the program has been provided through collection of data, staff and patient comments at S.T.P.H., and evaluation by the professional community.

Data collected in the calendar year prior to implementation of the program and in the year following implementation of the program show that incidents of disturbed behavior decreased by 9 per cent; incidents of patient injuries decreased by 12 per cent; patient-related staff injuries decreased by 10 per cent; and hours lost because of injuries decreased by 31 per cent.

Subjective staff and patient comments indicate that both groups now feel more comfortable. Staff are less apprehensive about injuring either themselves or the patient during a physical confrontation. Patients generally feel more comfortable since they perceive staff as being more efficient and capable of providing assistance to themselves or others if the need arises.

In September 1976 the American Psychiatric Association presented a gold award to S.T.P.H. for its significant contribution to the field of mental health in developing this program. Since then, the hospital has received many requests for assistance from other institutions and has responded by providing a total of 16 two or three-day workshops attended by close to 300 registrants. Participants

have come from as far west as British Columbia and as far south as Texas. They have included representatives of provincial and state psychiatric hospitals, mental health clinics, general hospitals (with and without psychiatric units), corrections, retardation, and ambulance services. Many of these participants have indicated the great need for such a program and have expressed surprise at the simplicity of learning the moves.

Marketing

In order to make the program available to agencies whose staff could not attend workshops in St. Thomas, a teaching package that included a videocassette and workbook was prepared by S.T.P.H. staff and produced by the Ontario Ministry of Health. Response to the teaching package was so enthusiastic — the first printing of 238 copies of the videocassette and 1500 copies of the workbook was sold out — that a second edition was prepared, and has been available since April 1, 1978. This revised edition incorporates suggestions from staff and workshop participants as well as some modifications of physical intervention techniques based on further experience.

Conclusion

The program which we have introduced at S.T.P.H. and are now sharing with interested health care workers in Canada and the United States, has several points in its favor. One is its "portability" in its present packaging; another is the simplicity of both the teaching and learning aspects of its message. Above all, it offers a safer working environment for everyone engaged in the provision of "people services" and the promise of more efficient and humane treatment for those on the receiving end of this care.

Lillian Stegne, the author of "A positive approach to negative behavior," has been staff development coordinator at St. Thomas Psychiatric Hospital for the past five years. Her publications in this field include, in addition to the videocassette and workbook, "Prevention and Management of Disturbed Behavior," another Ontario Ministry of Health document, "Guidelines for Psychiatric Nursing Program for Nursing Assistants."

A graduate of McMaster University (B.Sc.N.) and University of Ottawa (Diploma in Nursing Education), she is currently taking part-time studies in the M. Ed. program at the University of Western Ontario. Before joining the staff of S.T.P.H., the author was employed by the Ontario Ministry of Health as a nursing education consultant in the Mental Health Division.

Frankly Speaking

Who needs whom?

Donna Ciliska

Not too long ago, while working in a community health agency, I became aware of a problem that, once identified, I recognized as one I had already encountered in hospital and clinic settings. The problem is this: nurses often interact with patients in a manner that satisfies their own needs but encourages, creates or maintains dependence on the part of the patient.

"Not true!" you say. "I've been taught from the first day of nursing school to assist patients towards becoming independent.¹ My function is to meet the patient's needs; I don't expect the patient to meet mine!"

seen many instances where a nurse, primarily out of her need to be needed, performs activities for a patient that the patient is quite able to do for himself. My contention is that the nurse who does this encourages dependent behavior to the detriment of the patient's well-being.² Even though the patient may be grateful initially for the dependent role, the long-term result is to impede his adjustment to illness or disability. When this happens discharge from nursing services can be a devastating experience — for the patient and for the family who are left with the demanding family member.

Let me share some examples with you:

1. Sixty-three-year-old Mrs. J. recently suffered a cerebral vascular accident resulting in left-sided weakness. At bath time, the nurse repeatedly allows Mrs. J. to lie passively on the bed while she gives Mrs. J. her entire sponge bath.

The nurse may do this for any or all of the following reasons:

- It takes less time for the nurse to bathe Mrs. J., than for Mrs. J. to do as much as she can by herself. Saving time is a positively valued goal. The nurse may meet her own need for achievement in this way. She may receive positive reinforcement from her peers or superiors.
- The nurse will likely be rewarded by the patient through positive remarks such as: "You're my favorite nurse. The other nurses won't help me as much." Thus, the nurse's need to be needed is satisfied as well.

The outcome of such actions by the nurse is predictable. The patient will not gain or keep the necessary skills to manage her life without a nurse.



It's true that this is exactly what our nursing instructors told us. But do we put these maxims into practice?

I am sure that you could give me many examples of nurse-patient interactions where you have encouraged and assisted patients toward independence. On the other hand, I have

2. In hospital, nurses control and give out medications to patients who are quite capable of managing their own medications. This practice communicates to patients that hospital personnel feel they are, for one reason or another, incompetent.

The community health nurse conveys the same message when she

arranges various appointments for families, who, again, could easily manage that responsibility themselves.

In situations such as these, does the nurse derive a feeling of superiority? Do they boost her self-esteem because they imply that she is the only person in the situation who is capable of carrying out these functions when in fact, she is producing feelings of inferiority and low self-esteem in her patients so that they feel incapable of taking meds or arranging appointments upon discharge from nursing services?

3. Some community nurses, consciously or unconsciously, retain patients on their caseloads longer than necessary because they neglect to begin teaching the skills that will allow the patient and family to function safely without the aid of a nurse.

When this happens it is because the nurse wants to enhance her own self-esteem through feeling superior in the knowledge she holds that the patient does not? Could it be because she wants her co-workers and superiors to think: "Look how hard that nurse works. She carries more patients on her caseload than anyone else." Such a situation may also enhance her feelings of job security. After all, how could the administration dismiss someone who works so hard? Unfortunately, it is the patient who suffers in this type of interaction. It is his independence that is sacrificed and at considerable cost to the health care system.

A solution

Research tells us that young women enter nursing because they "want to help people want to be needed."³ When we first went into nursing, most of us were aware of an apparent conflict between this desire to help and be needed as opposed to the need of our patients to achieve optimal independence. As time went on however, and our experience increased, we realized that our patients really did need us very much to learn the skills they must have to gain or maintain independence. We came to appreciate the fact that we could help by teaching

and encouraging each patient to "do for himself." We realized that without our help many patients simply could not function.

Unfortunately, in the process, we tended to lose sight of the possibility that our need to be needed might conflict with our patients' need to be independent. We forgot that in every interaction we have with our patients the potential exists for producing or maintaining dependence or fostering independence. The choice is ours. I believe that the way to solve this problem and to make sure that no nurse encourages, creates or maintains dependence on the part of any of her patients, is to institute a program of "consciousness raising" related to patient independence.

If head nurses and supervisors let it be known that they expect their staff to foster independence in their patients, these nurses will make sure that they incorporate area and level of dependence in their assessments, and make optimal independence a written goal on nursing care plans. Their interventions will be designed to reach this goal. Regular supervisor/peer review of care plans and regular focusing on optimal independence would help staff members to focus on patients' level of independence. Periodic change of assignments and proper discharge planning would also help.

I feel confident that through continuing dialogue with patients and colleagues on the subject, we can maintain our awareness of the patient's need for optimal independence and still meet our own need to be needed, our needs for self-esteem and achievement by assisting the individual to become independent once again. ♡

Donna Ciliska, who is the author of this month's Frankly Speaking, works as a staff nurse with the London-St. Thomas Branch of the Victorian Order of Nurses, in London, Ontario. She is a graduate of Victoria Hospital School of Nursing and received her B.Sc.N. and M.Sc.N. from the University of Western Ontario.



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- 3 Skipper, J.K. *Social interaction and patient care*, by ... and Robert C. Leonard. Toronto, Lippincott, 1965. p. 335.

Explore the World of Nursing with Saunders

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Immensely popular in its previous edition, this new revised version offers the latest coverage of contemporary topics including: respiratory therapy, quality assurance, nursing audit, stoma care, biofeedback, and more.

By the late **Benjamin F. Miller, MD**; and **Claire B. Keane, RN, BS, MEd**. 1148 pp. 139 ill. (16 color plates) March 1978. Flexible binding, thumb-indexed \$18.65. Order #6357-5. Hardbound, not thumb-indexed: \$15.35. Order #6358-3.

Gillies & Alyn: SAUNDERS TESTS FOR SELF-EVALUATION OF NURSING COMPETENCE, 3rd Edition

Thoroughly up-dated, this complete curriculum review covers many new topics including: amniocentesis, hyperbilirubinemia, lead poisoning, laryngeal carcinoma, and paraplegia.

By **Dee Ann Gillies, RN, BS, MA, MAT, EdD**; and **Irene Barrett Alyn, RN, AB, MSN, PhD**. 496 pp. \$12.30. April 1978. Order #4132-6.

Moore: REALITIES IN CHILDBEARING

This relevant book examines maternity nursing in a socio-cultural context with discussions of such current issues as consumer desires vs. traditional nursing practices, and cultural differences in childbearing among Black, Spanish-American, Asian, and single parent families.

By **Mary Lou Moore, RN, MA**; with a contribution by **Ora Strickland Davis, RN, PhD**. About 770 pp., 220 ill. About \$17.95. Just Ready. Order #6497-0.

Barnard, Clancy & Krantz: HUMAN SEXUALITY FOR HEALTH PROFESSIONALS

Here's everything you need to know about human sexuality, so that you can effectively counsel patients—from abortion to infertility to sexual deviancy.

By **Martha Underwood Barnard, RN, MN**; **Barbara J. Clancy, RN, MSN**; and **Kermit E. Krantz, MD**. About 300 pp. Illustd. Soft cover. About \$14.55. April 1978. Order #1544-9.

Falconer et al: CURRENT DRUG HANDBOOK 1978-1980

Completely up-dated, this handy reference lists over 1500 drugs—their generic and major trade names, sources, dosages, uses, and much more—all in an easily accessible tabular format.

By **Mary W. Falconer, RN, BA, MA**; **H. Robert Patterson, BS, MS, PharmD**; **Edward A. Gustafson, BS, PharmD**; and **Eleanor Sheridan, RN, BSN, MSN**. 312 pp. Soft cover. \$8.40. March 1978. Order #3568-7.

Falconer et al: THE DRUG, THE NURSE, THE PATIENT, 6th Edition

New to this edition are increased clinical nursing material by new co-author Sheridan; up-to-date data on IV administration, cancer chemotherapy, pain, and allergies; and the inclusion of the 1978-1980 Current Drug Handbook.

By **Mary W. Falconer, RN, BA, MA**; **Eleanor Sheridan, RN, BSN, MSN**; **H. Robert Patterson, BS, MS, PharmD**; and **Edward A. Gustafson, BS, PharmD**. 671 pp. Illustd. \$19.90. March 1978. Order #3549-0.

Phillips & Feeney: THE CARDIAC RHYTHMS: A Systematic Approach to Interpretation

Invaluable for self-instruction, this handy workbook is an explicit step-by-step guide to understanding both the normal heart beat and the abnormal rhythms.

By **Raymond E. Phillips, MD, FACP**; and **Mary Kay Feeney, RN, BSN**. 354 pp. 928 ill. \$16.25. Oct. 1973. Order #7220-5.

Dolan: NURSING IN SOCIETY: A Historical Perspective, 14th Edition

Trace the development of nursing—its response to both society and science—from ancient cultural practices to contemporary care, with this popular text. A *Teacher's Manual* is available.

By **Josephine A. Dolan, MS, PhD, RN**. About 465 pp., 290 ill. About \$21.30. Ready July 1978. Order #3133-9.

Luckmann & Sorensen: MEDICAL-SURGICAL NURSING:

A Psychophysiologic Approach

A virtual encyclopedia of effective patient care, this clearly written text examines general concepts related to illness, and care of both the total body and specific body systems.

By **Joan Luckmann, RN, BS, MA**; and **Karen Creason Sorensen, RN, BS, MN**. 1634 pp. 422 ill. \$25.20. Sept. 1974. Order #5805-9.

Guyton: TEXTBOOK OF MEDICAL PHYSIOLOGY, 5th Edition

Selected an *AJN Book of the Year*, this popular physiology textbook for medical students is also a superb reference for nurses. It's organized by body systems and includes relevant clinical physiology.

By **Arthur C. Guyton, MD**. 1194 pp. 804 ill. \$29.15. Jan. 1976. Order #4393-0.

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Names and Faces



Lily M. Turnbull has been appointed to the University of Saskatchewan's continuing nursing education office, College of Nursing, to coordinate a new program focusing on the aged. The office, established in 1971 to help nurses across the province keep abreast of new developments in their profession, is expanding into gerontology, the study of aging and geriatrics and the care of the aged. In her new position, Turnbull will be gathering information on the educational needs of nurses working with the elderly, identifying and evaluating educational material and resources for teaching and training and proposing methods for implementing projects in caring for the aged.

Prior to this appointment, Turnbull was the chief nursing officer of the World Health Organization. She began her career with WHO in Malaysia in 1952 and later was appointed regional nursing advisor, Western Pacific Region. In 1969 she became WHO's chief nursing officer. A graduate of the Regina General Hospital School of Nursing, she received a B.N. from McGill University and a Master's in Public Health degree from The Johns Hopkins University.

Dorothy Hall, an internationally known Canadian nurse working with the World Health

Organization, will receive an honorary doctor of laws (LL.D.) at this year's Spring Convocation at the University of Western Ontario.

Hall has been involved in the development of nursing, nursing education and the delivery of health care since she first joined WHO in 1955 as a nurse educator/advisor in Thailand. Since then, she has helped in the planning and development of nursing education in Ceylon, India, Afghanistan, Burma, Indonesia, Mongolia, the Maldives Islands and Nepal.

Currently she is the regional officer for nursing for the European Regional Office of WHO. She is responsible for the nursing/midwifery and medicosocial aspects of the regional program. In this post she is closely involved in the development of university education in nursing in Iceland, Belgium, Finland, Italy, Poland, the Federal Republic of Germany and the U.K.

The previous director of the nursing division, Registered Nurses Association of Ontario, **Dorothy M. Wylie**, has been appointed vice-president, nursing, at the Toronto General Hospital.

Wylie is a graduate of St. Michael's Hospital School of Nursing, Toronto and obtained her certificate in public health nursing at the University of Toronto. From 1962 to 1969, she held a number of positions at Cornell Medical Centre, New York, during which time she received her B.Sc.N. from New York University and a Master of Arts from Columbia. On her return to Toronto, she held the positions of assistant director, clinical nursing, Scarborough Centenary Hospital; assistant professor, Faculty of Nursing,

University of Toronto; and assistant executive director of patient care, Sunnybrook Medical Centre.

Wylie is a member of a number of associations including the RNAO, CNA and the Canadian College of Health Service Executives. She is a member of the council for the College of Nurses of Ontario and a member of the board of the Victorian Order of Nurses for Metropolitan Toronto.



Peggy Anne Field, was chosen as the Canadian candidate for one of the 3M-International Council of Nursing Fellowships by the Canadian Nurses Association selection committee.

Field received a \$200 stipend at a luncheon in Edmonton hosted by 3M Canada Limited and competed with candidates from other countries for one of two \$6,000 international fellowships. Established in 1969 by the International Council of Nurses and the Medical Products Division of 3M Company, the fellowships are administered and judged by the ICN. They are open to nurses in more than 60 countries and are awarded annually for formal study in the nurse's field of interest.

Field obtained her S.R.N. at Addembrooke's Hospital, Cambridge, England in 1953, and in 1962 received her diploma in Teaching and

Supervision from the School of Graduate Nurses, McGill University, Montreal. In 1966 she obtained her M.N. from the University of Washington, Seattle.

An associate professor at the University of Alberta since 1974, she has held various positions as coordinator, special programs, assistant professor and lecturer at the Edmonton-based university since 1966. She has held the post of chairman on several committees of the Alberta Association of Registered Nurses from 1965 to the present time.

Pauline Mella of Tanzania and **Teresa Chopoorian** of the United States are the winners of the two 3M Nursing Fellowships for 1978.

Mella is nursing officer in charge, Nursing Education Department and School of Nurse Teachers, Muhimbili Medical Centre, Dar Es Salaam, Tanzania. She plans to use the 3M fellowship to study for a Bachelor of Science in nursing education in the U.S. On her return home, she will prepare post-basic teachers in nursing, continue with her involvement in school administration and prepare policies relating to nursing education.

Teresa Chopoorian will pursue a doctoral degree in education. She is particularly interested in how future societal trends will influence health practices and the delivery of health service, and in the development of appropriate models for nursing education. A member of the Massachusetts Nurses Association, Chopoorian is also an assistant professor of nursing and associate coordinator of a project for nursing education.

Audiovisual

■ Pediatrics

I'll Find a Way



An Academy Award winning film produced by the National Film Board of Canada. The film is about Nadia De Franco, a nine-year-old girl with spina bifida. Nadia walks with crutches and a brace, swims with running shoes on and plays basketball from a wheelchair, but her vitality and wit make the film a real celebration of life. Nadia expresses how it feels to be a person with spina bifida, to be a little girl who wants to be treated like everybody else. This film is one of a series of NFB films about children in Canada. 16mm. Color. Length: 23 minutes.

For information write: National Film Board of Canada, P.O. Box 6100, Montreal, Quebec, H3C 2H5.

Photo courtesy of the National Film Board of Canada.

■ Professional Your Professional Association

A full color slide-tape show about the Canadian Nurses Association and what it does for nurses in Canada. The presentation spells out the importance of the association to nurses on a local, provincial and international level.

It shows the relationship of the association to the development of standards,

discipline and ethics. It also takes a look at some of the specific functions of CNA through research, CNA's Testing Service, Labor Relations Services, the CNA Library and the two journals *The Canadian Nurse* and *L'infirmière canadienne*. A colorful and lively production. Produced by the Canadian Nurses Association in 1977. Length: 12 minutes. Price for a package of 62 slides, audiocassette and script: \$75.00

Your Professional Association will be presented at the CNA Convention in the Ontario Room of the Royal York Hotel, Toronto, from 12:30 to 14:00 hours on Tuesday, June 27th, 1978.

■ Mental Health Prevention and management of disturbed behavior

A package including one videocassette and 10 workbooks on the prevention and management of disturbed behavior. Discusses the causes and recognition of disturbed behavior, prevention, the St. Thomas Psychiatric Hospital approach to such behavior and principles of intervention designed to protect both staff and patients. Prepared by Lillian R. Stegne and published by the Ontario Ministry of Health.

Copies of the manual and videocassette are available from the Ontario Government Bookstore, 880 Bay Street, Toronto, Ontario, M7A 1N8. Cheques may be made out to the Treasurer of Ontario. The total package of one videocassette and ten workbooks is \$75.00 (plus sales tax); single copies of the workbook are \$3.00 each; and one copy of the videocassette \$50.00 (plus sales tax).

Further information on the prevention and management of disturbed behavior may be obtained from Miss L.R. Stegne, Staff Development Coordinator, St. Thomas Psychiatric Hospital, Box 2004, St. Thomas, Ontario, N5P 3V9.

■ Communication Peege

A 28-minute 16mm color film about communication. A family visits their aging grandmother in a nursing home at Christmas to find her remote and unresponsive to all their attempts to reach her. The film looks at the feelings and behavior of the family

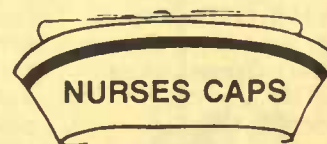
members in their frustrated efforts to communicate and shows how the barriers are finally broken down. Produced by Phoenix Films. Approximate rental fee: \$40.00.

For information write International Telefilm Enterprises, 47 Densley Ave., Toronto, Ontario M6M 5A8.

Did you know ...

The Ontario Ministry of Health has produced a 34-page booklet, "Current issues in Infant Feeding: A Guide for Professionals." Copies may be obtained from: Health Promotion Branch, Ontario Ministry of Health, 2nd Floor, 7 Overlea Blvd., Toronto, Ontario, M4H 1A8.

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Library Update

Publications recently received in the Canadian Nurses Association Library are available *on loan* — with the exception of items marked **R** — to CNA members, schools of nursing, and other institutions. Items marked **R** include reference and archive material that does not go out on loan. Theses, also **R**, are on Reserve and go out on Interlibrary Loan only.

Requests for loans, maximum 3 at a time, should be made on a standard Interlibrary Loan form or by letter giving author, title and item number in this list.

If you wish to purchase a book, contact your local bookstore or the publisher.

Books and documents

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Ethics in Human Experimentation Report No. 6, The Medical Research Council, Ottawa, Canada, Supply and Services Canada, March 1978.

Research involving human subjects raises many questions that are the concern of the community as a whole. The Medical Research Council established a working group to study these questions. **Ethics in Human Experimentation** is the bilingual report of the Working Group on Human Experimentation.

Copies of the report will be available free at the CNA booth at the CNA Convention in Toronto, June 25 to 28, 1978. You may also obtain a copy by writing: The Publications Department, Canadian Nurses Association, 50 The Driveway, Ottawa, Canada, K2P 1E2.

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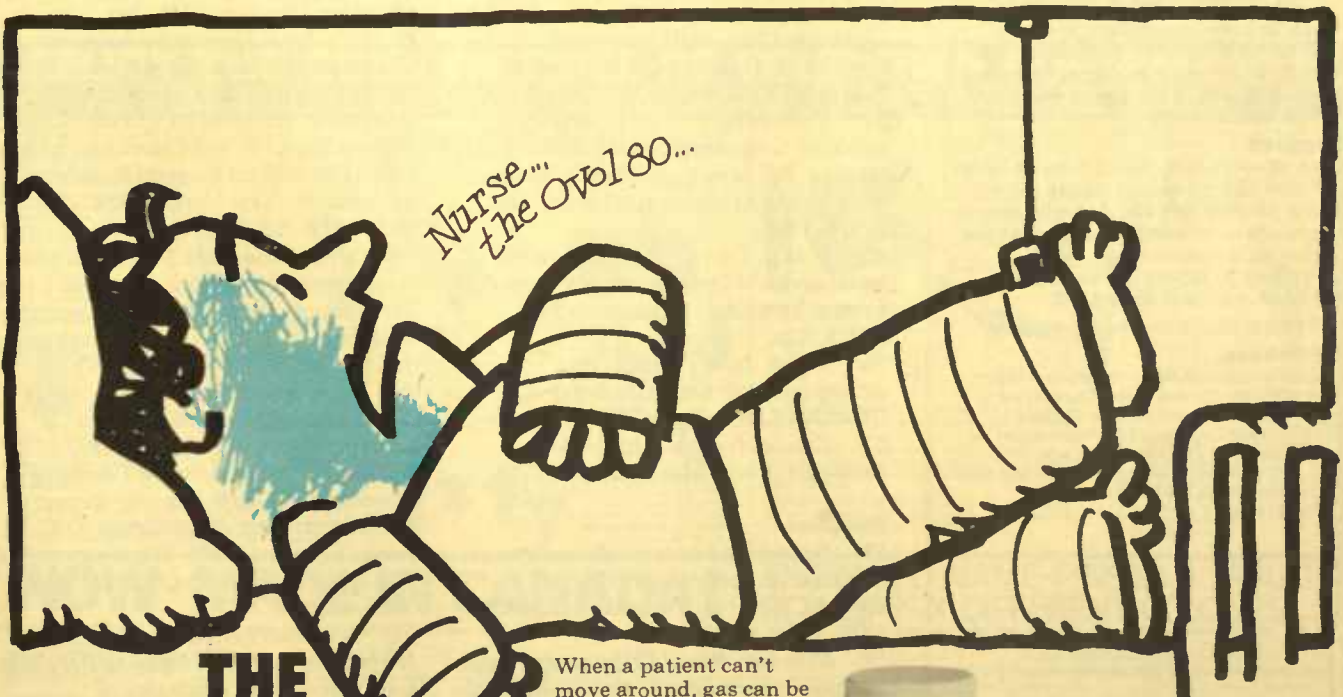
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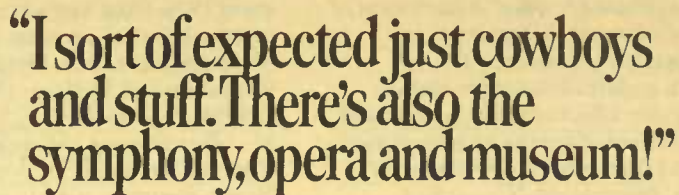
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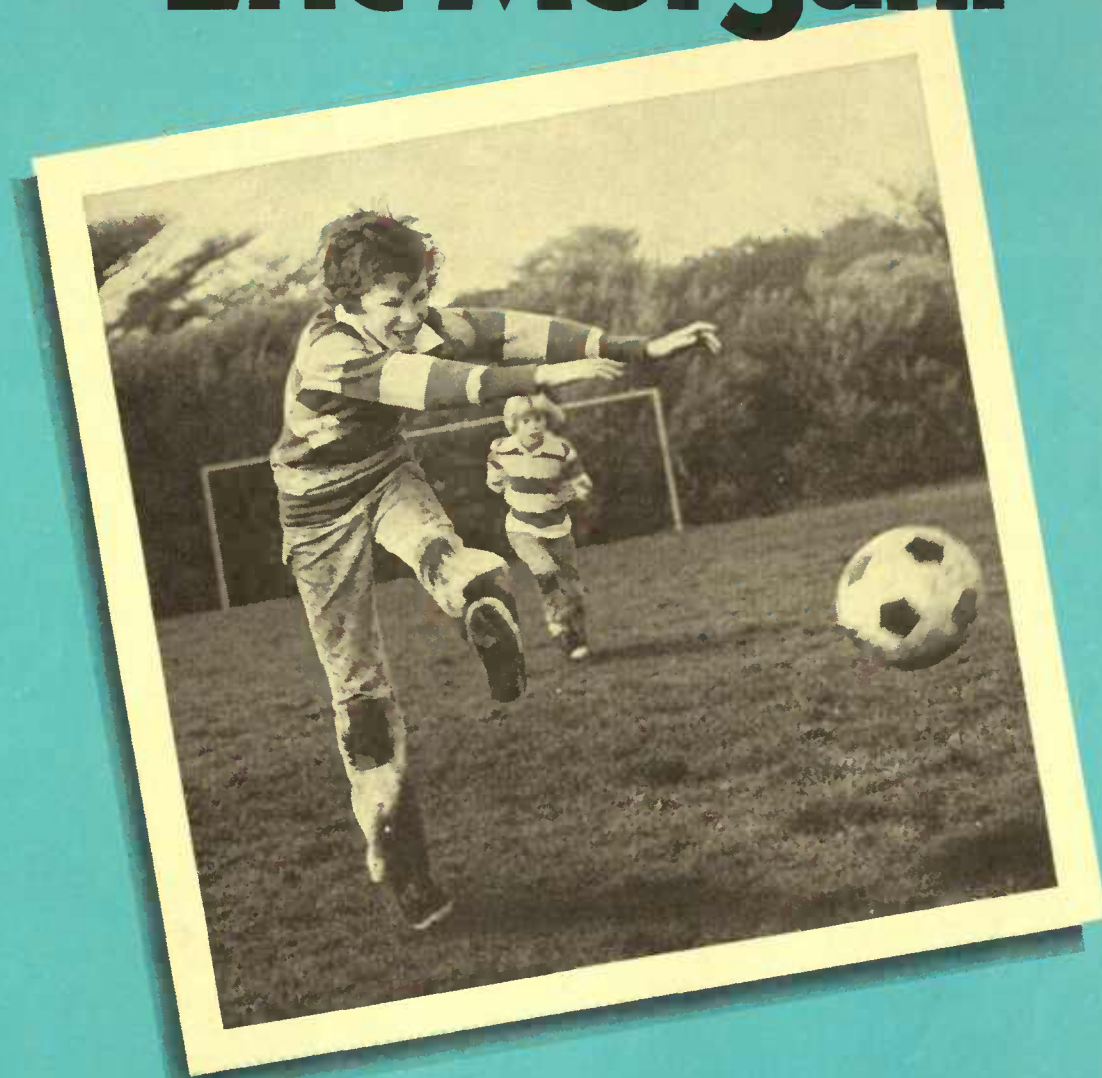
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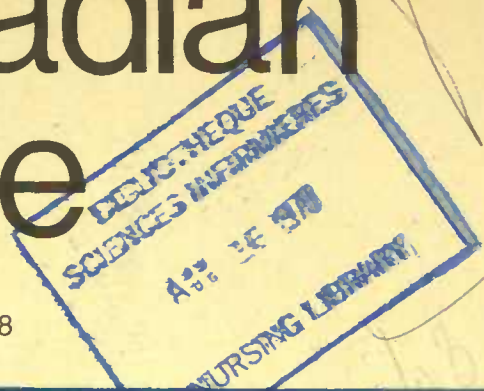
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The Canadian Nurse

JULY/AUGUST 1978



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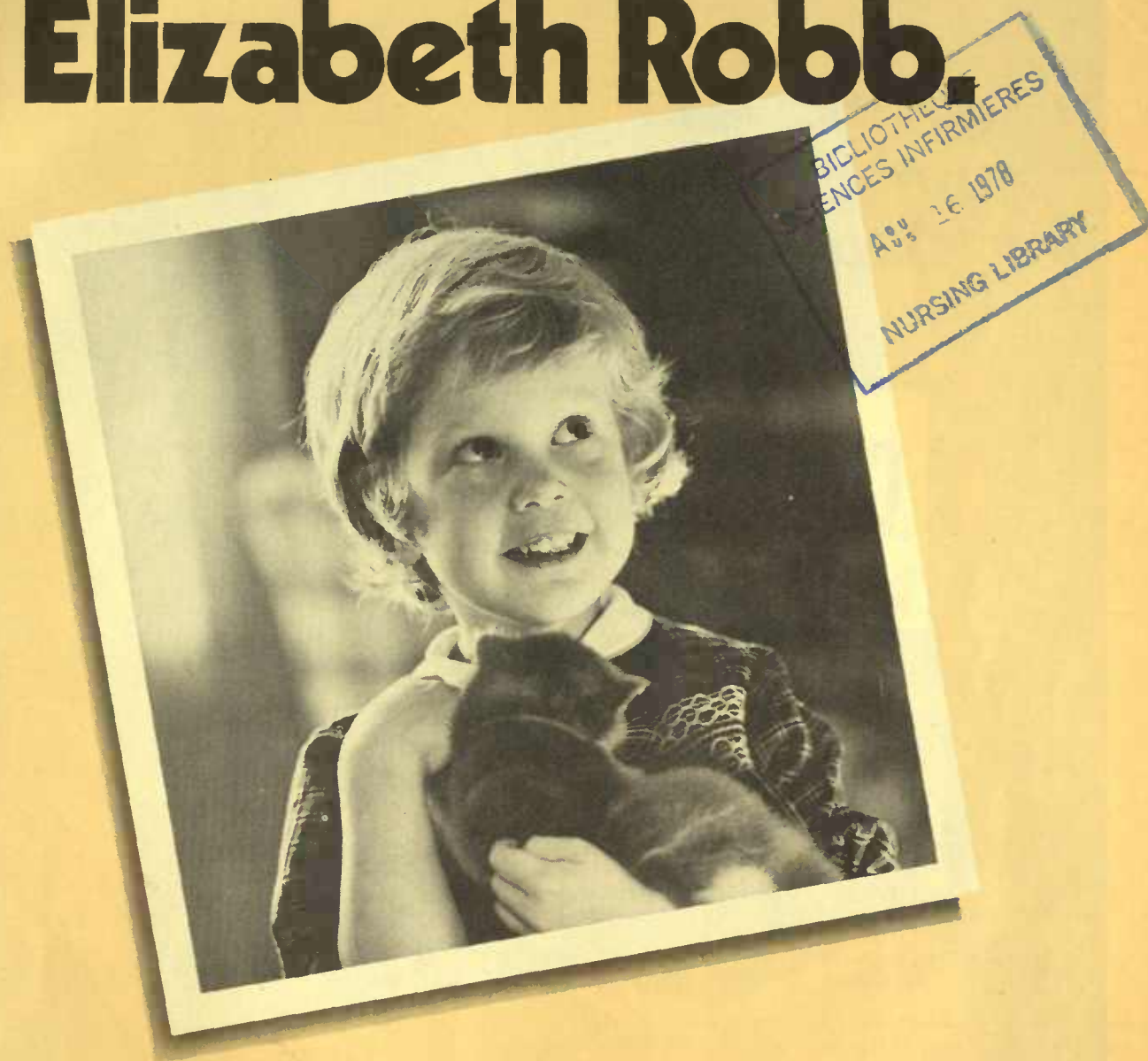
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The Canadian Nurse

JULY/AUGUST 1978

The official journal of the Canadian Nurses Association published monthly in French and English editions.

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Canada's own Pied Piper, Bobby Gimby, composer of the 1967 Centennial theme song, "Canada," was on hand to get this year's annual meeting and convention of the Canadian Nurses Association off to a rousing start. Fittingly enough, the meeting, which took place in Toronto from June 25 to 28, coincided with the celebration of Canada Week. Cover photo and all convention photos by George Schroeder, Photomedia Productions, Toronto.

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses Association.

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Input

A satisfied reader

Congratulations and thank you for the marvelous articles in the last few issues of *The Canadian Nurse*.

My hat is off to you for making the magazine so interesting and informative. Usually I read *The Canadian Nurse* and then quickly forget it but now I await each new issue with anticipation.

Keep up the good work — it is most appreciated.
— *Verlie Chisholm, Reg. N., Birtle, Man.*

Food for thought

The March issue of *The Canadian Nurse* is of particular value and interest to the staff and volunteers of nursing homes. I would like to express my thanks for the comprehensive articles which are so useful in preparing inservice educational programs; also for comparison of how others approach caring for the elderly and what it's like to be a person entering an institution. Certainly food for thought.

The legal aspect of charting and nursing care is most informative and useful in avoiding potential liability.

My gratitude for an excellent issue directed to those providing extended care.
— *Pamela MacLean, Reg. N., President, St. Raphael's Nursing Homes Ltd., Scarborough, Ontario.*

More about charting

This is an appreciation of "You and the Law," a newly added feature in the journal. This is something that we nurses need today and should be aware of. The article on charting was a good start — every practicing nurse should know the legal implications of accurate recording in the nurses' notes.

I felt however that the author should have also discussed something about methods of charting used in nursing homes and other long-term care facilities. In these institutions, some patients are considered independent and pretty much on their own. I hope to read articles about this aspect of charting too.

The articles on gerontology in the March '78 issue were very interesting and informative. Gerontology is a specialty gaining much attention at the present time. I am glad to be a charge nurse in a nursing home, because I love to work with and care for elderly people.
— *Myndah Derro, R.N., B.S.N., The Pas, Manitoba.*

The patient's choice?

Corinne Sklar's article "The patient's choice vs. the nurse's judgment" in the April 1978 *Canadian Nurse* was very distressing. It advocated a denial of a patient's choice regarding his own treatment. Here we have a patient who knew his prognosis and had "read extensively about his illness and treatment." Not only did Sklar support deliberately misinforming the patient as to the pain medication he was receiving, but also supported the supposition that the nurse knew more about the pain the patient was having than did the patient himself. A more reasonable approach might have been to give the patient sufficient information about both demerol and morphine and their relative analgesic qualities and encourage him to choose for himself. (Indeed, he might have even had this information already and had made a well-informed, rational decision.)

While the nursing profession is striving for more

patient-directed health care, the advocacy of such authoritarian judgment and aggressive nursing care smacks of concentration camp tactics.

— *Catherine Fenton, B.Sc.N., Hamilton, Ontario.*

I think that the case was mishandled from an ethical point of view, and that the action taken was poorly defended.

Peter was aware of his condition, his prognosis and his treatment. He had consciously chosen by critical examination of his circumstances to exercise the right to decide which drug he required for pain relief. Presumably, the nurse's reasoning in administering morphine rather than demerol was to relieve intolerable pain. Surely it is up to the patient to determine what to him is intolerable. If he wishes to withstand the pain in order to experience other things, then he probably can withstand it. Otherwise, he can request morphine. There are reasons at times which can justify otherwise immoral acts of lying, but in this case, Peter's request was reasonable and voluntary, yet his clearly stated preference was overridden by the action taken by another. Again, one is justified at times in exercising authority over another person when there are good reasons to believe that "the other" is unable to himself make a rational decision. I think this is not the situation in Peter's case.

Sklar's arguments in defence of the action taken are specious. She states, "A patient cannot demand mistreatment." Surely this patient was not demanding mistreatment; again she reports, "A patient stating a preference in the absence of

pain clearly has the right to change his mind." This is true, but irrelevant since this patient did not change his mind.

The April article is useful in bringing to our attention, as nurses, the importance of our role in being "with" others during their last stage of growth.

— *Louise Corbett, R.N., Dalhousie Family Medicine Centre, Halifax, N.S.*

Nurses do not always know what is best for other people. It is important to remember that a hospitalized person is not only a "patient," he is an individual with the same human rights as he had before he entered the hospital.

Perhaps the *legal* issue discussed in this article is entirely beside the point.

— *Judy Worms, R.N., Vancouver, B.C.*

As a patient, person and consumer of professional services, Peter's rights were sold short and not respected by the nurse. Morphine does not relieve the pain; it only alleviates the intensity by elevation of the pain threshold. Could we as nurses become more communicative with patients? Patients are people with illness and pain, but most of all feelings and a wish to maintain their self-respect and dignity.
— *Barbara Palmer, R.N., Hillsborough, N.B.*

The author replies:

Several readers have written concerning this column to describe what in their view would have been a more professional nursing approach to the patient and his fear. Their approach involved talking to the patient and his wife, exploring his

The Canadian Nurse invites your letters. All correspondence is subject to editing and must be signed, although the author's name may be withheld on request.

fears with the goal of teaching, explaining and alleviating his anxieties. Clearly their approach would have been to build trust with the patient and sustain it through communication with him. With all of this I most heartily agree for this would have been the nursing approach of choice.

However, the focus of my column was not a discussion of acceptable alternative nursing courses of action. The column was examining the legal consequences, if any, that might arise out of this given situation. The course of conduct here did not necessarily in law fall below the legal standard of care required. The nurse in the example would have had several alternative nursing approaches from which to choose. She made a personal, professional judgment based on her assessment and acted upon it. Other nurses might not have made such a decision. The focus of the column was to examine the *legality of that nurse's choice of action* based on all the circumstances as they were given.

It must not be overlooked that the facts as given came from a third-hand report of the incident. Hence there is no additional information regarding the nursing care given prior to or following this incident. The legal opinion was based on the facts as received with as much speculative comment as could reasonably be derived from these facts.

Because there are uncertainties and gaps in the information, it is easy to speculate on what did happen, and what alternative nursing measures could or should have been instituted. However, the purpose of the column was to examine the given facts and to consider the

legal aspects so raised; it was not to outline preferable nursing alternatives. The latter I leave to you the readers for your discussion and consideration of the professional aspects, as these correspondents have so ably done.

—Corinne Sklar.

Work history important

It was with great interest that I read "A nurse practitioner at work" in the April issue of *The Canadian Nurse*. The article covers many an aspect of my day-to-day experience as a nurse working in industry.

In the first paragraph on page 26 of the article, Bonnie talks about the patient's health history. Although later in the article she confirms that she knows what her patient's jobs are, it would appear meaningful to obtain a detailed occupational health history of the patient as well — especially in preventive medicine.

—J. Scharfenberger, Tomahawk, Alberta.

Moving to Québec?

The Bureau of the Ordre des infirmières et infirmiers du Québec wishes to inform nurses of decisions it has made which will affect the status of candidates who have already or will receive a letter of acceptance for admission to the practice of nursing in Québec.

These decisions are as follows:

- as of March 16, 1978, all letters of acceptance for admission to the practice of nursing sent to candidates from outside Quebec must state that the conditions specified are valid for a period of two (2) years, from the date of said letter.
- only letters of acceptance

issued during the last three (3) years preceding the entry into force of the decision of the Bureau, be honored for a one (1) year period.

- as of January 1st, 1979, following complete evaluation of documents and the granting of equivalence, the examinations for admission to practise nursing will be required by all candidates for admission to the profession, who have completed their nursing studies outside Canada or the United States of America.

—Gertrude Jacobs, N., B.N., Registrar, Order of Nurses of Québec.

Herein

Looking ahead ... readers of *The Canadian Nurse* can look forward to not one, not two, but THREE special issues over the next few months. In the works now are plans for feature reports on three subjects that we think are important to all nurses, no matter what their experience or background.

The first will be a special issue dedicated to an examination of the nature and quality of the health care that Canada's native people, the 1,000,000 Indian and Inuit who share their country with us, are receiving — who gives it, who receives it and, most of all, what role nurses play in all of this.

The second special issue, also planned for this Fall will provide readers with a look at how Canadian nurses are facing up to the issues involved in caring for the terminally ill patient. Our "death and dying issue" promises to provide a thoughtful look at this sensitive area of nursing practice from many points of view, including death in the home and what it's like to work

on a palliative care unit.

The third special issue of CNJ will appear next January and is planned to coincide with the kickoff celebrations for the International Year of the Child. Its subject, naturally, will be the "little people" whose special year it is in 1979.

Naturally, if you think you have something special to say about any of these extremely important areas of nursing experience, we'd be more than pleased to have you share your views with us.

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Perspective



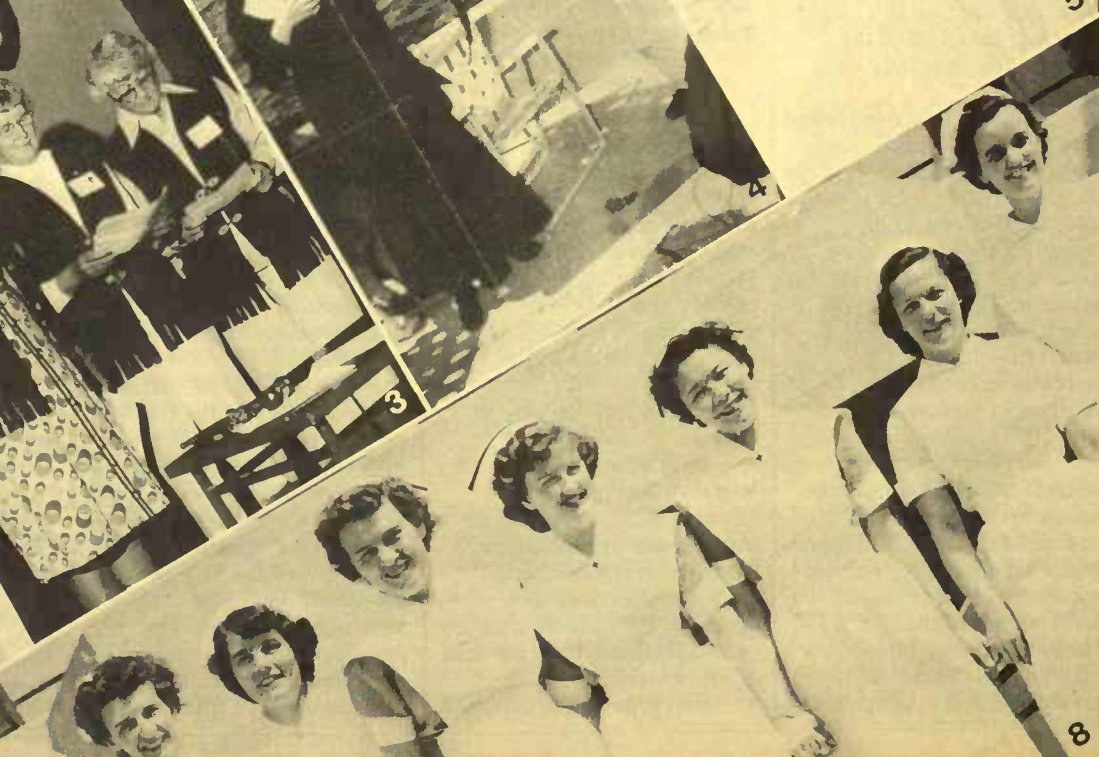
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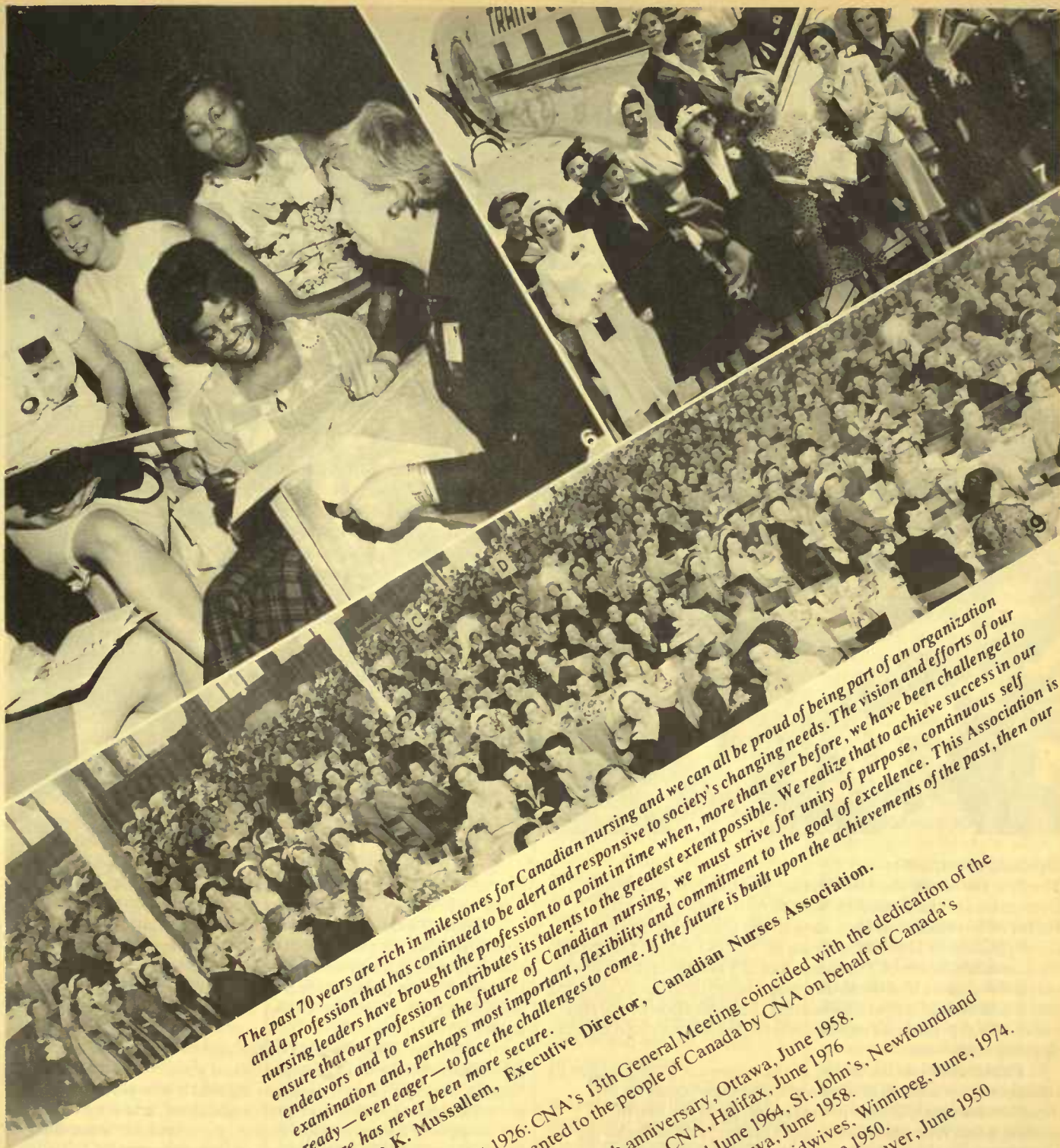
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The past 70 years are rich in milestones for Canadian nursing and we can all be proud of being part of an organization and a profession that has continued to be alert and responsive to society's changing needs. The vision and efforts of our nursing leaders have brought the profession to a point in time when, more than ever before, we have been challenged to ensure that our profession contributes its talents to the greatest extent possible. We realize that to achieve success in our endeavors and to ensure the future of Canadian nursing, we must strive for unity of purpose, continuous self examination and, perhaps most important, flexibility and commitment to the goal of excellence. This Association is ready—even eager—to face the challenges to come. If the future is built upon the achievements of the past, then our future has never been more secure.

— Helen K. Mussallem, Executive Director, Canadian Nurses Association.

- Ottawa August 1926: CNA's 13th General Meeting coincided with the dedication of the War Memorial presented to the people of Canada by CNA on behalf of Canada's Nursing Sisters.
- Voting delegates. CNAs 50th anniversary, Ottawa, June 1958.
- Northwest Territories nurses join CNA, Halifax, June 1976
- CNA's 32nd Biennial Convention held June 1964, St. John's, Newfoundland
- CNA's 50th anniversary celebrations, Ottawa, June 1958.
- First meeting, National Committee of Nurse-Midwives, Winnipeg, June, 1974.
- Arriving in Vancouver for CNA's 25th Biennial, June 1950.
- VGH student nurse guides, CNA's 25th Biennial, Vancouver, June 1950
- CNA Convention Banquet, U.B.C., Vancouver, June 1950

CONVENTION '78

Ethical Issues in Nursing



Opening ceremonies

The first sounds of the 43rd Annual Meeting and Biennial Convention of the Canadian Nurses Association were the voices of 40 children as they sang to the trumpet of Bobby Gimby. Close to 1200 nurses from all across Canada gathered in the Canadian Room of Toronto's Royal York Hotel for a lively musical welcome to a three-day meeting designed to explore the moral and ethical issues confronting the profession of nursing today. CNA president Joan Gilchrist acted as chairman for the opening ceremonies.

Explorations of the theme of the convention were begun by student nurses who offered two cultural viewpoints on the direction nursing will take in the future. **Jocelyne Morin**, a student nurse from the province of Québec, talked about the need for constant renewal within the profession, and the importance of knowing the limits and prerogatives of nursing service. **Donna Wicks**, a student nurse at Seneca College in Toronto, addressed the need for nurses to get involved in a future of preventive health care, meeting people in the marketplace and using nursing skills to teach them to become involved in their own health care programs. In thanking the students for their viewpoints, CNA director **Lorine Besel** said that it was only fitting that the meeting be begun from a student perspective, that nurses needed to be "haunted by a vision of the future and not by the ghosts of our past."

Greetings to the convention were read by Helen Mussallem, CNA's executive director. They came from Prime Minister Pierre Elliot Trudeau, from Olive Anstey, president of the International Council of Nurses, and Anne Zimmerman and

Myrtle K. Aydelotte, president and executive director of the American Nurses Association respectively.

Dennis Timbrell, Ontario's minister of health extended a welcome from the province of Ontario. He spoke of the need for preventive health and individual responsibility in health care. He said that the nurses' role in preventive care is 'pivotal' in this time of transition that marks the deinstitutionalization of health care.

Alderman **Janet Howard** of the city of Toronto offered greetings from the city. Howard talked about the importance of 'fragile' services like nursing, saying that it was essential for nurses to insist on their own professionalism, and ensure that in the process of deinstitutionalization, patients had "something at home in order to live as members of their community."

Margaret Cameron of the World Health Organization suggested that members remember to keep an international rather than national perspective and remember that technology has a built-in value system, and that these values can be imposed on the nursing profession.

Irmajean Bajnok, president of the Registered Nurses' Association of Ontario, welcomed delegates to the convention. Acknowledging that a national convention was possible only through the wonders of technology, Bajnok said that it was important to really look at the other side — the human side — of technology that challenges the nurses' view of life and death, and blurs vision between right and wrong. We are here, she said, to look at those gray areas that pose ethical dilemmas, to look at the issues involved in technology and changing mores.

Professional versus consumer rights

The opening address to CNA convention delegates centered on the rights of patients, the consumers of health care. **Bernadette Walsh**, a staff nurse in obstetrics at St. Joseph's Hospital, North Bay, Ontario, asked nurses to consider the grave ethical questions which concern patients caught up in the health care system.

As medical technology advances Walsh said, there is a danger that patients will pay the price, doomed "to a life of survival on the slimmest of human terms." Continual scientific advances mean that the patients' rights and dignity may be compromised. As the public becomes aware of the problem, legislation such as the Patient's Bill of Rights and living wills will become more common, to protect the patient from becoming "a pawn of health professionals within the arrogant hierarchy of the healing profession."

The ethical questions which concern the rights of patients and health professionals must be confronted now, warned Walsh. She challenged nurses, as the largest body of health care professionals in Canada, to act to find compromises and solutions which will both "protect and promote the rights of the patient" and "still allow the health profession to practise freely, unhampered by legal impediments."

Bernadette Walsh has worked in several hospitals in both northern and southern Ontario. She has held executive positions in the Registered Nurses Association of Ontario for the past three years. In 1977, she was a member of the RNAO Steering Committee for the Protection of Life. She is also the author of "One Gentle Man" (*The Canadian Nurse*, April, 1977).

Ethical concerns

What ARE the everyday realities of ethical concerns for nurses? For most members of the profession, according to **Dr. David Roy** these realities involve facing up to the fact that nurses are responsible, not just to the patient, but also to the patient's family, the physician(s) involved, their fellow nurses and their employer (usually the hospital).

"In practice," Dr. Roy pointed out, "this makes it almost inevitable that sooner or later the individual nurse is going to find herself carrying out an order with which she disagrees, perhaps violently." When this happens, the resulting conflict, confrontation and consensus can make the nurse who is involved a key figure in the determination of ethical policy in the institution where she works.

Dr. Roy, who is director of the Centre for Bioethics, Clinical Institute for Research in Montreal, made the observation during his kickoff address to delegates gathered for the three-day CNA convention which had as its theme "ethical issues in nursing." He noted that within the last six years members of the health care community have become increasingly aware of the value choices that they face in their day-to-day work. As proof, he cited six real life situations submitted to him by nurses for comment and analysis. The cases consisted of six situations, each of which shared a common component of conflict between the ethical value judgment of the nurse concerned and the decisions of the other health care personnel involved. The patients in these cases included:

- a severely defective newborn;
- a person undergoing transsexual surgery;
- a cancer patient receiving continuous doses of morphine;

- a cancer patient whose physician refused to prescribe more than the minimal dosage of morphine;
- a patient whose attending physician refused to inform him of his diagnosis in the face of imminent death;
- a brain-damaged patient placed on a ventilator.



Dr. Roy set out four canons or fundamental rules that members of the nursing or medical profession might use as guidelines in attempting to resolve the ethical concerns that face them in their practice. The first, he suggested, was the notion that when medicine cannot effect a cure, it must help the patient to live with his disability. The second is the idea that the ultimate function of medicine is to integrate the possibilities that each patient represents so as to achieve the maximum human potential.

The third canon involves acceptance of the principle that when further therapeutic treatment becomes useless, then non-treatment is right and ethically justifiable. The fourth principle, according to Dr. Roy, involves acceptance of the belief that even in cases where medicine cannot effect a cure and non-treatment is accepted, medicine does not have the right to kill. "At some point," Dr. Roy observed,

"the nurse has to stand up for her responsibility to the patient rather than the physician, but she should be careful in her choice of the time and place for this ethical debate. She should not, for example, choose the operating room or delivery room when a surgical procedure or delivery is in process. Dr. Roy had two suggestions for long-term solutions to the problem of ethical conflict between nurses and other health professionals. The first involved the institution of a series of ongoing seminars to educate health professionals in how to meet and deal with the ethical situations they encounter. The second suggestion was to urge nurses to present the viewpoint of the nursing profession, not just in their own professional journals for other nurses to read, but also in medical journals where doctors will have the opportunity to learn more about the ideas and concerns of other members of the health team.

"Nurses," Dr. Roy pointed out, "have a range of competence, responsibility and experience that should be brought to bear on what we have been accustomed to think of as medical problems."

Dr. Roy was introduced by the dean of nursing of Queen's University in Kingston, Ontario, **Alice Baumgart** who reminded her audience that "nursing has always pursued questions of ethics but a combination of factors in recent years have made the ethical dilemma that nurses face more acute.

"In an era of economic restraint, for example" she asked, "how do we determine our priorities? How do we ration health services unless we can develop new guidelines."

Nursing ethics in the schools

Nursing is no place for "ethical orphans" according to three panelists who took part in a discussion on ethical issues in professional development on the opening morning of the convention. Both Dr. Margaret Scott-Wright, director of the school of nursing of Dalhousie University, and Margaret Neylan, head of the department of psychiatry at the British Columbia Institute of Technology, agreed with fellow speaker ethicist Dr. Abbyann Lynch of the department of philosophy at University of Toronto St. Michael's College, that nursing and ethics are inevitably intertwined and that the individual nurse is called upon to make many "ethical" decisions in her everyday practice.

"Nurses have indicated consistently in their practice and more recently in their literature," Dr. Lynch observed, "that they are unwilling to ignore the 'ethical.' In a sense, the objection that learning 'ethics' is too difficult, is overturned by nurses' behavior. There seems to be no question that more explicit knowledge of 'ethics' will be demanded by nurses — both students and those in practice — and that more ethical expertise will be demanded of nurses by the public."

Dr. Lynch called on the nursing profession to foster the preparation of nurse-ethicists to instruct nursing students in ethics. "Ethicists never exposed to clinical areas or without some understanding of the goal and content of nursing curricula are unsuitable (as instructors)," she said. "Neither they nor their students will understand what is to be done. Nurses without ethical preparation will not cope: nursing and ethics overlap, but they are not identical. The nurse-ethicist is the most suitable, if elusive, candidate."

"There is now great incentive in nursing to re-examine our basic roles, our models of professional practice, and our boundaries. Our concern must be to develop a professional who is creative, responsive, capable of representing new and more acceptable or desirable modes of behavior and skilled in managing the learning of these by the client.

"It is essential that we outgrow the conception of innovations as a single dramatic solution to a problem. Major changes may come about through successive, small innovations — a prolonged, diffuse and infinitely complex process. It is in this fashion that I believe we will solve many problems besetting the health professions and our services."

Dr. Lynch suggested that, until enough nurse-ethicists become available, the profession should encourage inclusion of the study of ethics in all post-graduate programs for nursing educators, recognize interdisciplinary credits and provide financial aid. Nurses should also make sure that the study of ethics is included in all nursing programs, pre-professional and ongoing. "For personnel," she suggested, "use the instructors available. The nurse educator who is trained in ethics is obviously the best role model for the student who will function as a nurse in making ethical decisions."

Dr. Margaret Scott-Wright supported the importance of ethical preparation for nurses since "ethical judgments must always precede nursing assessments." She suggested that until nurse-ethicists become available, the profession make use of non-nurse-ethicists and support them in their efforts by providing them with the information they need in order to function adequately. A long-term goal she said is the preparation of sufficient numbers of nurse-ethicists

capable of functioning in the interdisciplinary arena.

A slightly different point of view was put forward by the third speaker on the panel, Margaret Neylan, who suggested that "nursing ethics must permeate the curriculum since nurses learn about ethics through their practice. As a profession we cannot accept that this important task be left in the hands of ethicists."

She stressed that schools should recognize that students entering nursing do so with existing ethical beliefs and the job of teachers is to assist in merging these beliefs with the nursing ethics they propose to teach. Within nursing education itself, she

suggested, there are at least five ethical issues that should be concerning the profession at the present time. These include:

- the use of patients for teaching purposes;
- selection methods for students entering nursing education programs;
- maintenance of clinical competence of nursing instructors;
- the protection of the students' rights to privacy, particularly the confidentiality of records;
- the judgment involved in decisions regarding the expenditure of public funds so as to provide the greatest possible benefit to both patients and students.

Ethics of nursing research

The question of ethics in nursing research was addressed by four nurses who have distinguished themselves in the field. A roundtable



discussion, hosted by **Laurier Lapierre**, professor and historian, CBC radio and TV personality, included the following participants: Dr. **Moyra Allen**, professor and director of research at the McGill University school of nursing; **HUGUETTE Labelle**, director general, Policy Research and Evaluation Branch of the Department of Indian and Northern Affairs; **Marie-France Thibadeau**, associate professor, of the University of Montreal's school of nursing, and **Beverlee Cox**, dean, faculty of nursing, University of Western Ontario.



Huguette Labelle

Each of these participants identified the research projects in which they were involved, and then discussed the ethical issues as they saw them. Moyra Allen discussed the problem of informed consent as it relates to



Marie-France Thibadeau

community research projects. Huguette Labelle talked about the rising expectations brought about by the presence of research projects and the conflicting value systems and cultural differences between the researcher and those who are the subject of research. The problem of privacy and informed consent as it relates to research with psychiatric patients was discussed by Beverlee Cox. Marie-France Thibaut talked of how important it is for research to share the ethics of service, so that research is not merely an intruder but part of the caring profession that is missing.

The professional association meets the challenge

What are the ways in which the professional association of nursing can meet the ethical challenge facing nurses today? This question was addressed by Marguerite Schumacher, dean of the faculty of nursing at the University of Calgary, Calgary, Alberta, and Sheila Belton, past president of the Saskatchewan Registered Nurses Association at CNA's 43rd Annual Meeting and Biennial Convention.

Schumacher presented to delegates a number of areas



in which Canada's national nurses' association must continue to give leadership as well as exploring new avenues of direction for consideration. She challenged CNA to give leadership in the following areas related to ethical issues facing nursing today:

- to identify situations related to the ethics of competence and the ethics of compassion;
- to reexamine the Code of Ethics and to operationalize the statements using real life situations;
- to examine the meaning of the terms ethics, bioethics, bio-science, public ethics, in light of their applicability to the ethical issues within nursing;

- to extend CNA's outreach with organizations or associations of both professional and consumer groups who are studying and grappling with ethical issues related to health, illness and the quality of life;
- to prepare a discussion paper on the concept of euthanasia and the quality of life.

Sheila Belton spoke of the importance of critical self-evaluation in the nursing profession. This reflection, she said, is the "heart" of ethics. She stated that in order to continue nursing's commitment to improve the health and well-being of people, the profession needs strong moral and ethical leadership. "By their very nature, the provincial associations stand as the leadership mechanism of the profession.

"Every nursing relationship begins with an unusual burden, of ethical responsibility ... in his dependency he (the patient) must be able to assume that he will receive care that is safe, effective and morally responsible." Belton stated that it is the one-to-one nurse — patient interaction that is the most critical of all.

How can provincial nursing associations provide leadership on the ethical issues that confront every

nurse? Belton said that nurses must deal individually and collectively with the implications of advancing knowledge and technology, that they must become "futuristically-based" in order to better forecast consumer needs, and that they must take an informed stand on consumer needs.

How can nurses prepare themselves to cope with the ethical questions of the future? Belton suggested that nurses take a look at the provincial systems of nursing education to see what they are doing to help students cope with ethical problems. She said "... formal preparation of faculty members to teach ethical aspects, and recognition of this responsibility as part of a faculty load, is a specific sign of commitment on the part of a school." She also referred to the provincial code of ethics as a framework to help nurses identify their duties and obligations toward the patient and the public.

"Our influence," she said, "will depend on the strength of our professional voice, a voice that will lead a profession of commitment and action."



Some of the CNA delegates were off and running every morning through the streets of Toronto as they maintained their own personal fitness programs.

The frontiers of science and humanity

Technological advances have confronted inventive man with a moral dilemma. Roy Bonisteel, TV personality and host of CBC-TV's *Man Alive*, told delegates to CNA's 43rd Annual Meeting and Biennial Convention that the key to the dilemma posed by these technological advances lies in considering "how we may become more human."

He told an attentive audience that technology has brought with it a "shift in our moral universe." Because man can prolong life by artificial means, because organ transplantation has made the "composite man" a reality, man's traditional understanding of his world becomes inadequate. Bonisteel said that it is because technology enables man to keep life going that he must make certain that he is not merely prolonging the dying process needlessly.

Technology, he said, has developed ahead of ethics and law. Man is now looking at what human life is, in order to find necessary definitions of life and death. And the question is difficult, said Bonisteel because it is evident that man is more than a physical "system of organs and functions," that he is "a rational creature with the ability to love and be loved."



Bonisteel said that too often man's solution to the dilemma posed by technology lies in more technology, a sidestep that avoids moral responsibility. He added that "health problems are often rooted in cultural priorities," that because technology is

profitable in dollars and cents and we value financial gain over concern for others, technology is seen as more important. "Concern for others is not profitable."

Instead of continuing to create more of everything, Bonisteel said, we need to change our values and our lifestyles. He said that in our busy world, many of us have fallen into the habits of the *me* decade, where giving is not valued, but rejected along with "loyalty, patriotism, discipline, skill and stoicism."

"The essence of humanness lies in the de-emphasis of ME," said Bonisteel, "in reaching out with love to others." He added that it is because the nurse reaches out to others that she is the one safeguard in the system of health care. He said that it is the development of this capacity to love another human being that will help man to understand and solve moral dilemmas and find the borders between what he can do and what he may do.



A look toward the future

The closing address of CNA's Annual Meeting and Biennial Convention was presented by Josephine Flaherty, Principal Nursing Officer, Health and Welfare Canada, who led delegates in a thoughtful consideration of what the future holds for the profession of nursing in Canada.

Dr. Flaherty said that given the realization that a society in flux is a fact of our daily lives, "accountable health professionals may have to rethink and redefine their purposes, their nature and their value systems.

"To do this, they will require personal philosophies that are meaningful to them, explicit definitions of their ethical beliefs, identification of their own personal -professional conflicts and acknowledgment of the extent to which they are imposing these on others and to which these conflicts affect the health care provided."

In this ever-changing society, nurses are constantly called upon to make important decisions and Flaherty said that these decisions will have a far-reaching influence on the future health of Canadians. She said that it is because of these responsibilities that each nurse must really "know nursing." She stressed the importance of looking very closely at what is going on, critically examining nursing within the present health care system and striving for excellence in practice.

Flaherty outlined those professional characteristics that enable nurses to face the complex situations and weighty decisions that they must make in a competent way:

- general and specific education, enabling the nurse to develop the ability to think and reason, and to know the specific theory on which to base her work;

- a code of ethics that concerns the value and dignity of human life and is subject to change as society also changes;

- dedication to the ideal of master craftsmanship, involving knowledge and comprehension of theory put into practice;

- knowledgeable participation in a professional structure; and

- accountability or taking of responsibility for one's own professional actions.

"Nurses who are professionally accountable recognize that the direction of scientific discovery and its application to mankind are not out of their hands. They have personal, professional and legal responsibilities to ask probing questions about scientific and technical research and its application (or lack of it) in practice."

Flaherty said that ethics in health care "is not restricted to pieties in conference rooms," but "a necessary, useful and productive basis for action." She said that the task ahead of nursing is considerable but that nurses must use all their efforts towards the improvement of nursing care. "The individual roles of our members are complex, but their possibilities are unlimited."



More than 45 exhibitors, the largest number in CNA history, were present for the three days of the CNA convention. Above, two nurses visit the display sponsored by the Canada Health Survey Division of Health and Welfare Canada.

Highlights from the report of the executive director

"The past 70 years have not altered the primary focus of our association, which is 'to promote high standards of nursing practice and nursing education in order to provide quality care for the people of Canada.' Nevertheless, our methods of responding to the needs of an ever-evolving society and world have dramatically changed the scope and complexity of CNA's programs and activities. ... The watchword that emerges from the work of the past biennium would seem to be 'standards'. In our efforts to cope with change, we have sought home bases from which to venture — bases against which the effects of change can be weighed and measured ..."

Standards

"CNA's commitment to standards is self-evident and we believe real progress has been made over the past two years.

- In March, 1978, CNA directors approved the final report of the ad hoc committee on standards for NURSING EDUCATION. These national standards for nursing education are a first in Canada and an historic landmark for the nursing profession.

- The development of national standards for NURSING PRACTICE was also established as a priority for this biennium. At the same time, CNA directors identified the need for a definition of nursing practice and during 1977 a director (Norah O'Leary, a nursing consultant with Health and Welfare Canada) was appointed to supervise both projects. A 14-member steering committee has already met and reported to CNA directors. The definition of nursing practice and standards will be submitted to CNA directors for final consideration before publication and they will be identified as products of the nursing profession. The project is financed by Health and Welfare Canada.

Labor relations

Following establishment of a labor relations service at the beginning of 1977, CNA has begun to provide members, provincial/territorial nurses' associations, collective bargaining organizations and other related groups with information and assistance in the area of research and education in labor relations.

Comprehensive examination

The CNA Testing Service which, since 1970, has developed and provided examinations for graduates of nursing programs seeking registration in each of the 11 Canadian jurisdictions, has given priority during this biennium to the development of a comprehensive examination to be based on a nursing rather than a medical model. The examination, scheduled to be completed in 1980, is being developed in both official languages.

Registration

A discussion paper on registration/ licensure has been prepared by a project director (Wendy Gerhard) appointed by CNA directors.

Research

CNA has been actively engaged in the promotion of nursing research for many years and the increasing volume of studies is reflected in the association's publication, *Index of Canadian Nursing Studies*.

- As Canada's national nursing library, the CNA library has been recognized as a pioneer in the compilation and indexing of nursing research studies; many other organizations have now established similar collections based on the CNA model.
- Recently, representatives of CNA, the Canadian Nurses Foundation and the Canadian Association of University Schools of Nursing have developed a joint approach to nursing research that promises to lead to a closer working relationship between these organizations.

- In November 1977, CNA, in cooperation with the school of nursing of the University of Ottawa, sponsored a workshop in research methodology in nursing care funded by a National Health Grant and the Secretary of State. Workshop proceedings in both French and English are available from CNA.

Health promotion

Phase one of a CNA Health promotion program for nurses, which included a workshop for nurse teachers held at Geneva Park in Ontario, was completed in 1977. Funding for this program was provided by a grant of \$23,124 from Health and Welfare Canada's Fitness and Amateur Sport Branch. In 1978 other commitments made it necessary for the association to take a less active role in this area and CNA decided instead to support an application by the Victorian Order of Nurses for funding to carry out phases two and three of the project. Funds for the project have since been awarded to the VON by Health and Welfare Canada.

Protection of life

A CNA task force was appointed to assist the Protection of Life Project of the Law Reform Commission of Canada and members met with commission officials in January 1978. Discussion was stimulating and productive and the commission has indicated that this task force will be convened again.

Liaison

- Two organizations — the Canadian Association of Neurological and Neurosurgical Nurses and the Canadian Nurses Respiratory Society — were granted affiliate member status in CNA during the biennium.
- The Canadian Hospital Association/Canadian Medical Association/Canadian Nurses Association Joint Committee, which first met in 1948, continues to meet on a regular basis to discuss mutual concerns. The Canadian Public Health Association has also been invited to attend the next meeting.
- In 1977, a CNA first was recorded when the association's president-elect, Helen Taylor, was named chairman of the board of directors of the Canadian Council on Hospital Accreditation. CNA has been represented on the CCHA board since 1973 but last year marked the first time a representative of the organized nursing profession had been chosen to serve as chairman. CNA's other representative on the CCHA board is former member-at-large for nursing administration, Fernande Harrison.

International meetings

More than 600 Canadian nurses were among the 12,000 participants from 68 of the 88 ICN member associations who attended the 16th quadrennial congress of the International Council of Nurses in Tokyo May 30 to June 3, 1977. CNA president Joan Gilchrist was Canada's official spokesman.

Membership

At December 31, 1977, CNA membership stood at 122,460, (compared to 115,584 at the same date in 1976).

Canadian Nurses Foundation elects directors for 1978-80



One of the highlights of the annual meeting of the Canadian Nurses Foundation was the presentation of a cheque for \$6,750 to the CNF from the Registered Nurses Association of Ontario: Above, RNAO president Irmajean Bajnok (right) makes the presentation to CNF director Margaret McLean.

"The largest turnout in the history of the Canadian Nurses Foundation," was how CNF president Margaret McLean described this year's participation in the organization's annual general meeting. Close to 200 CNF members attended the meeting which coincided with the opening day of the CNA annual meeting in Toronto.

In her address to the nurses attending the meeting, president McLean urged members to carry out an active recruiting campaign. She pointed out that although membership had increased in 1977, it was still well below the peak reached in 1965 when more than 1600 nurses were members of CNF.

Secretary-treasurer Helen K. Mussallem in her report to membership noted that the 12 scholarships awarded this year to Canadian nurses, brought the total of CNF scholarship awards since 1962 to 190. The awards, 162 for studies at the master's level and 28 for doctoral studies, have a total monetary value of \$518,172.

The secretary-treasurer noted that since 1970, when master's level programs in nursing became available in

Canada, there has been a noticeable trend towards the choice of Canadian graduate schools over those in the U.S. by fellowship winners.

A highlight of the meeting was the unveiling of the new CNF logo which will be used in the future to identify the association. The logo, designed by Ottawa graphic artist Ian Robert, was chosen over a total of more than 200 designs submitted during a national contest.

Also during the meeting, RNAO president Irmajean Bajnok, on behalf of the Ontario association, presented CNF president Margaret McLean with a cheque for \$6,750 as "a public acknowledgment of the contribution that CNF has made and is making to Canadian nursing."

CNF directors elected for the coming biennium are: **Barbara Archibald**, program manager, program development and evaluation, Health Division, Statistics Canada; **Denise Lalancette**, associate professor, University of Sherbrooke, Qué.; **Margaret D. McLean**, director, School of Nursing, Memorial University, St. John's, Nfld.; **Shirley**

McLeod, associate professor, University of New Brunswick; **M. Louise Tod**, executive director, Manitoba Association of Registered Nurses.

Business session

Delegates used the second day of the three-day convention to accomplish the business of the association consisting mainly of an accounting by CNA's top officials of activities carried out during the past biennium on behalf of membership. In addition to the reports of president **Joan Gilchrist** and executive director **Helen Mussallem** (reported separately), two reports on CNA committee activities were received by delegates.

Chairman **Helen P. Glass** presented the report of the eleven-member Special Committee on Nursing Research whose activities included review and comments on two public reports and assistance in organization of a workshop on research methodology in nursing care held in Ottawa in November, 1977.



Jean Dalziel

The report of the Committee on Testing Service, whose members represent the ten provincial jurisdictions which use the CNATS examinations, was presented by chairman **Jean Dalziel**. Delegates also approved three changes in CNA Bylaws as well as the report by president-elect **Helen Taylor** on the proposed budget for 1978. (See *The Canadian Nurse*, April, 1978).



National seminar to look at doctoral studies for nurses

The Canadian Nurses Foundation has received from the W.K. Kellogg Foundation a grant of \$38,250 to assist the Canadian Nurses Association and the Canadian Association of University Schools of Nursing in conducting a National Seminar on Doctoral Preparation for Canadian Nurses to be held in Ottawa, November 1-3.

Announcement of the grant was made during the recent meeting of the national nurses' association in Toronto. The seminar program will focus on major issues, trends and problems related to doctoral preparation for nurses, including an assessment of national needs for such professionals and the resources currently available for their training.

There are no Canadian doctoral programs in nursing. Only about 50 of Canada's estimated 190,000 registered nurses have doctoral degrees, most of which were obtained in the United States.

Seminar participants will include representatives of Canadian schools of nursing already offering master's programs, representatives of related professional associations and key university and government personnel.

Founded by the breakfast cereal pioneer W.K. Kellogg in 1930, the Kellogg Foundation is among the five largest private philanthropic organizations in the United States. It supports projects in the areas of health, education and agriculture on four continents.

Highlights from meeting of CNA Directors, Toronto

June 22 and 23, 1978

Consumer representation

The governing body of Canada's national organization of nurses, in existence for 70 years, has moved to include non-nurses in its deliberations and decision making.

After listening to the representatives of provincial associations which already have lay representation on their boards describe their experience in this area, CNA's directors voted to invite three consumer representatives to become members of the CNA board.

Five provinces — British Columbia, Manitoba, Québec, Saskatchewan and New Brunswick — now name non-nurses to their boards. These provincial representatives were unanimous in their opinion that lay representatives make a valuable contribution to their activities. As one president said: "We're not afraid to say we're accountable to the public; we welcome them as equal members."

Two-year programs

A committee of the board will review the conclusions and recommendations of the Ontario Ministry of Colleges and Universities contained in the recently published "Report of the Two Year Diploma Nursing Program in Colleges of Applied Arts and Technology in Ontario." The committee's response will be submitted to the Ministry in answer to a written request to CNA by the Ministry. A copy will also be sent to provincial association members and to the Ontario Ministry of Health.

Registration review

A discussion paper on registration/ licensure, "Principles, Alternatives and Strategies Related to Registration/Licensure by CNA Association Members," prepared by an outside consultant, Wendy Gerhard, at the direction of the CNA board, will be sent to the provincial associations for review and comment before the board reaches a decision on publication.

Service to members

Should non-members of CNA pay for the services they receive from the association? CNA directors will consider this question at their next meeting. Background information to assist them in their deliberations will be contained in a paper to be prepared by CNA staff.

Role of nurse-midwives

Nurses working in an extended role in obstetrical care in Canada can look forward to a joint statement from CNA and the Society of Obstetricians and Gynecologists of Canada on education for this role and its recognition by employing agencies.

Tentative agreement on the need for such a statement was reached during a meeting called at the request of SOGC and attended by the president of the National Committee of Nurse-Midwives, Pat Hayes, the director of nursing of the Ottawa-Carleton Regional Public Health Unit, Catherine McGregor Keys, and representatives of CNA.

CNA's executive director, reporting to the CNA board on the meeting, which was held in April at CNA House, said the statement will be prepared jointly by the SOGC and CNA (with reference to an earlier joint statement). The statement will follow presentation of SOGC recommendations on requirements for nurses within the discipline of obstetrics and gynecology (both within the hospital and in the community and home). Participants in the meeting also agreed on the need for a joint statement on lay midwifery and on the need for agreement on the legal status of the nurse-midwife.



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YOU AND THE LAW



Hospital hazards and the nurse

Corinne Sklar

Sometimes it is the little things that cause the biggest problems. Take the hot water bottle for instance. As simple and innocuous a device as anyone has ever come up with. And yet, you would probably be surprised at the number of nurses who have found themselves in a courtroom defending their nursing skills and judgment in using a hot water bottle as a comfort measure for one of their patients.

Or take the case of the freshly damp-mopped floor. A common obstacle for hospital staff who are familiar with institutional routine and avoid it because they know it is slippery. But what about the recently ambulatory patient who is gingerly making his way down the hall? Is he sufficiently aware of the danger that lies ahead?

As student nurses, one of the first things you learned was the importance of maintaining the safety and well-being of your patients. An important aspect of meeting this goal of providing safe nursing care, you were taught, is anticipation of the needs of the patient. Thus you learned, for example, to make it a habit always to place the call bell within the patient's reach when giving patient care.

What is the legal responsibility of the nurse with regard to conditions in the hospital and the equipment with which she works?

In general, hospitals are required by law to ensure that their facilities and the equipment they supply for diagnosis and treatment are safe and satisfactory in order to deliver proper health care. This does not mean that the hospital is required to supply the "very best and very latest" in equipment and appliances but rather that facilities and equipment should be maintained in reasonably fit condition for the uses and purposes intended under the circumstances. The nurse as an employee of the hospital and as one of the major users of the equipment and appliances furnished by the hospital has a major role to play in seeing that patients are not injured through the use of defective materials or misapplication of fit hospital materials. The misapplication of equipment, or the use by the nurse of defective equipment resulting in harm to the patient may result in hospital liability or liability to the nurse herself.

Hospital liability for the negligence of employees derives

from the legal doctrine of "respondeat superior" which, roughly translated, means "let the master answer." As the employer or principal, the hospital is primarily responsible when harm is caused to the person or property of another by one of its employees or agents. The employer is responsible because he has the power to select and dismiss personnel and it is the hospital's responsibility to hire capable staff.

The nurse has a duty to inform the hospital of matters affecting hospital interests. Therefore nurses have a duty to care properly for hospital equipment and to report any damaged or defective materials.

Nurses should report to the appropriate hospital authority equipment or furnishings that are or appear to be unsafe. Thus, electrical equipment with frayed cords, loose railings, broken window locks, weakened stretcher straps etc. should all be reported for repair. While to so report may seem simplistically obvious, it is not uncommon for wobbly wheelchairs or weakened restraints to remain in service, with the danger of potential injury to a patient. To permit injury through negligence, leaves open the possibility of liability in a lawsuit.

If a nurse fails to report defective materials or hazardous conditions and liability results from a lawsuit, it is possible that the nurse may not be protected by the hospital against the money damages awarded by the court. The failure to report may place the responsibility for the negligence squarely on the nurse alone. If the hospital had done all that it was reasonably required to do by law, i.e. inspect, furnish adequate materials, and had no knowledge of the defective equipment, the nurse's deliberate unreasonable use of the dangerous material may make her alone responsible to compensate the injured party for any damages awarded. While hospitals are responsible in law for the negligent acts of their employees, many factors are taken into consideration in the hospital's defence, such as employee's conduct within the scope of employment, willful disregard of instructions or hospital policy etc. A hospital may not be held responsible for the unreasonable conduct of an employee.

The hospital is also responsible for ensuring that its employees have a safe place in which to work, one which lives up to a reasonable standard of cleanliness and safety. The

hospital has a duty to warn staff and patients of any unsafe conditions; staff have a duty to report to the hospital any unsafe conditions they detect.

If a nurse who, having knowledge of a hazard or defect in equipment and failing to report it, is injured while at work, that nurse may find herself without recourse to compensation. If the hospital had no knowledge of the problem and had fulfilled its responsibility to take due care and reasonably inspect, it would not be liable. As the court said in *Bergeron V. Reilly and Chatham House Private Hospital*, the employee would have been the author of his/her own misfortune. In this case, a ward maid went to shake out a scarf while leaning over a fire escape railing. The rail gave way and she fell. However, she admitted that she knew the rail was loose before the accident but had not reported this to her employers. The hospital, despite periodic inspections, was unaware of the defect. She was therefore unable to recover compensation for her injuries, because she was deemed to have been contributorily negligent.

The law does distinguish between types of defects in equipment or conditions since to make hospitals and employees responsible for all kinds of defects would be an extraordinarily harsh burden. Thus the law distinguishes between *patent* defects, which are readily and reasonably observable, and *latent* defects, which are "hidden" or not easily detected.

Patent Defects

Patent defects in equipment or materials are those basically observable and disclosed through reasonable inspection. Frayed cords, loose wheels, frayed straps all fall into this category. Liability attaches for injury permitted by the continued use of such defective materials because staff and the hospital should have known that injury could result from such continued use. Failure to report and continued use of known defective equipment by nursing staff is negligent.

Latent Defects

However, if the defect is latent, that is not readily and reasonably observable, and injury results, liability does not necessarily follow. The following American cases illustrate these varying results:

- A nurse was shaking down a thermometer to take a patient's temperature when the thermometer broke, scattering glass and mercury bits in the patient's eye. The court found that there was no negligence. The hospital and staff had fulfilled their duty to the patient by furnishing standard equipment and making reasonable inspection of it for defects.
- In a Kansas decision, the patient was burned when the apparatus supporting a proctoclysis set broke. The nurse administering the treatment was found not negligent because the defect in the clamp was latent. The set had come ready for nursing use and the nurse had the right to believe that the equipment was safe and adequate to perform its function. It was not her duty to inspect its parts for latent defects.
- However, in a similar burn case, the clamp regulating the flow of the hot fluid failed to close properly. Here the hospital was liable for the nurse's failure to observe the defect. Although the defect in the clamp was not patent, a reasonable inspection of the clamp by the nurse would have disclosed the problem and the injury would have been averted. The court noted that although the clamp was a regular enema clamp, not one specifically part of a proctoclysis set, nevertheless its purpose was the same in either case, i.e. to control the flow of fluid. It was during this use and purpose that the injury was sustained.

Nurses should observe carefully the condition of the equipment they use. Rubber tubing does soften and weaken with use and time; clamps do fail and bindings weaken. One cannot assume that items that have worked effectively and efficiently before will automatically continue to do so. Nurses are not expected to be expert in their knowledge of all the inner



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workings and engineering aspects of the equipment they use but the law does require reasonable knowledge and expertise in practice and reasonable inspection of equipment by nurses.

Misuse of Equipment

Today, nurses work with a variety of equipment, some simple, some highly complex. The reported legal cases citing negligent use of equipment are dominated by burn cases. These arise from use of simple heat application devices: hot water bottles and heat lamps. The negligence of nurses here stems from their failure to adhere to the accepted standards of nursing care to be followed when such treatment is given.

It is therefore imperative to inspect the hot water bottle coverings to make sure they have not worn thin. The patient's skin should be adequately protected from direct contact with the heat source. The patient should be checked frequently during treatment. Do listen to the patient's statements about the treatment. What feels comfortable to you may in fact be burning the patient! In an Oregon case, the nurse did not heed the patient's complaints that she was being burned during a diathermy treatment. The nurse pretended to turn down the current. The patient's burns necessitated a two-week stay in bed. The court held the nurse alone liable for this negligence. Her employer, a physician, was not liable since the nurse had failed in her duty to her employer and she was fully aware of the consequences of applying excessive heat.

Frequent observation of the area is especially important when the patient is unconscious and heat is being applied. If lamps are being used, make sure that any protective shields are in place and that adjacent healthy skin areas are protected. Ensure that the patient does have the call bell accessible so that he/she may call for assistance if necessary. Because the application of heat can be relaxing and sleep inducing, do not rely on the patient to switch off the lamp or pad if so instructed. Check and be sure that the heat source is "off" when treatment is over.

Where patients have suffered burns resulting from the misapplication of these devices, nurses and hospitals have been held liable for the injuries sustained. The nurse must meet the standard of care required: that of a reasonable nurse of like training and experience.

Ensuring patient safety

Patient injuries sustained in hospital bathroom facilities — falls on slippery floors, or while in the tub or shower — are also common in the reported cases. While the cause of the accident may not be solely attributable to hospital or nursing negligence, nevertheless care should be taken to ensure that these facilities are as safe as possible for patients.

Decisions on liability for patient injuries turn on the circumstances of each case. Age, physical and mental condition are always relevant factors, as well as patient violations of staff's instructions. The condition of the patient should always be considered in nursing actions as well. Thus, to leave an elderly person alone after administering an enema might reasonably result in the patient's efforts to hurry to the bathroom unattended. A fall and injury in the process could result in liability.

What seems based on common sense and is commonplace can often be taken for granted. Nurses have to be aware that failure to observe and report defective equipment or unsafe conditions can result in injury to themselves or their patients. The fact that a piece of equipment as innocuous and simple as a hot water bottle has given rise to so many damage suits should serve as a warning that observation and listening are crucial to nursing practice and to preventing legal liability. While hospitals as employers are responsible for the negligence of their employees, nurses must remember that they too are answerable for their own negligence.

Diligence, due care and common sense are essential to protect nurses and the hospitals who employ them. The ultimate beneficiary is the patient whose safety and well-being are always major factors in the delivery of quality patient care.



"You and the law" is a regular column that appears each month in *The Canadian Nurse* and *L'infirmière canadienne*. Author Corinne L. Sklar is a nurse and recent graduate of the University of Toronto Faculty of Law.

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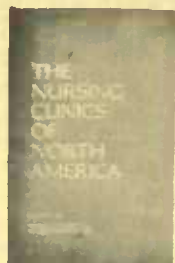
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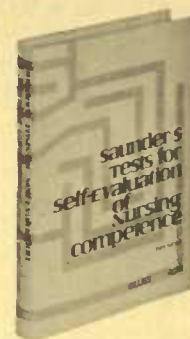
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News

B.C. nurses getting set to "work the system"

Registered nurses in B.C., faced with their president's prediction that "the coming year will bring one crisis after another in nursing care," are presenting a united front in their efforts to make sure that the level of patient care they provide in the future will be at least as good as in the past.

"Quality of care in practice settings is the single most important issue facing us today," RNABC president Sue Rothwell told B.C. nurses attending their association's 66th annual meeting in



Kelowna May 9 to 12. She described current problems at the province's largest teaching and referral center, Vancouver General Hospital, as "only the tip of the iceberg" and went on to list other concerns in the areas of home care follow-up, hospital staffing levels and extended care settings.

"All of us can think of examples where the nursing director, as the senior nurse in the agency, has gone to bat with administration and supported the professional judgment of those nurses who daily deliver patient care. And I think we can recognize that protection of nursing autonomy is not always easy, that it is the right of nurses to make suggestions, if not

decisions, about the things that affect nursing care.

"Within our own profession, the manifestations are even more alarming. Adversary positions develop among administration, middle management and staff nurses. Our association itself may be seen as an adversary since we are charged collectively through this body with legal responsibility for maintaining competence to practice. And it is a frightening situation when our professional association tells us we must be competent or face disciplinary action, and yet practice settings do not allow for competence.

"When we agreed to promote the health and welfare of the people of this province we undertook a very tough but rewarding commitment," Rothwell commented and urged the nurses in her audience to "honor thyself first and thy colleagues next."

RNABC members responded by giving a unanimous vote of support to their fellow nurses at Vancouver General Hospital who cite "a crisis in staff morale" at their hospital and say they "can no longer practice professional nursing in an autocratic climate where decisions are made without explanation, let alone consultation."

The vote of support took the form of a special resolution calling for an independent inquiry into the nursing situation at VGH. It was proposed during an emergency session of the association's board held during the convention and passed by members on the closing day of the convention. The request for the inquiry was rejected three days later by B.C. Health Minister Robert H. McClelland who stated that he had no

intention of intervening in the dispute which was "between the nurses and the administration and should be resolved by those two parties."

Nurses as policymakers

"Working the system" was the theme chosen by convention planners for the three-day meeting and delegates heard suggestions from a wide range of speakers on ways that they might play a more powerful part in policy making within the health care system. The suggestions came from political scientist and consultant, G.L. Kristianson, from RNABC member and dean of nursing at Queen's University in Kingston, Ontario, Alice Baumgart, and from the province's Minister of Health, Robert H. McClelland. In addition, three practising nurses described their own "adventures in influencing the system" and their experiences and reactions to assuming the role of change agent. The three were Anne Wylie, June Bandi and Elaine Carty (below).



Membership also approved a more active role for the association in terms of planned change within the health care system and the evolution of nursing roles and functions, when they passed a resolution urging the board of directors to appoint a Special Committee on the Future of Nursing. Commenting on the resolution, vice-president

Stephanie Grasset observed: "Nursing has been conspicuously absent as a political force. Changes are being hammered out by other groups and it is time we took this kind of political direction."

Woman power

Speaker Alice Baumgart also noted that "up until now we have been a group that has responded to crises; nursing has not carved out its own role in the policy making field." She criticized organized nursing for relying too heavily on volunteers, for "working to death our very few leaders," and urged professional associations to commit the necessary resources to obtaining advice and assistance from outside experts such as economists.



She advised nurses who wanted to see "more woman power in health care" to take note of the skilful politicians within the profession and to support these colleagues. "As a profession, we may have been handicapped by the small proportion of our membership who have achieved academic distinction. But education may not be as important as credibility and recognition of the significance of experience and interpersonal skills."

Speaker R.L. Kristianson also had some concrete advice to offer nurses on increasing their effectiveness as a pressure group working within the system. He urged RNABC

members to actively support their association, to ensure both the reality and appearance of militance, to demonstrate individual involvement and to make sure that at least some individual nurses take an active part in partisan politics.

He reminded them also of the advantages that nurses in B.C. have already acquired through their organization, including statutory recognition, credibility with the public and the right to consult with government representatives. During the business sessions of the convention, delegates approved a total of six resolutions from membership dealing with subjects that ranged from a proposed amendment to the Income Tax Act, allowing nurses to claim all expenses involved in continuing nursing education, to suggested revisions in provincial community care facilities regulations.

Members also approved a resolution calling for a judicial inquiry into the safety of the first uranium mine planned for B.C. and requesting the provincial government to ban any uranium mining in the province until after legislation to safeguard public health has been passed.

A special event during the convention was a farewell banquet in honor of retiring executive director, Nan Kennedy, who will be leaving the association in September.



Change lifestyle SRNA nurses told

The 61st annual meeting of the Saskatchewan Registered Nurses' Association was held in late May in Saskatoon. In order to increase nurses' awareness and participation in health promotion programs, "Health, Fitness and Lifestyle" was chosen as the theme for the annual meeting and convention.

In her opening remarks to the over 350 nurses present, SRNA president, **Sheila Belton** reminded nurses that, "As professionals we must ensure the provision of a safe level of practice and not be pressured to extend our services beyond set limits. We must set standards for nursing practice and develop a plan for the implementation of these standards." Belton announced the completion of the research study "Saskatchewan Registered Nurses' Perceptions of Quality of Care." Generally, the results of this survey indicate greater satisfaction than dissatisfaction with the care currently being provided. The results show there is a strong need to establish standards related to staffing, job qualifications, performance appraisal, nursing care plans, workload, patient assignment, records, patient teaching and nursing administration.

The lively response of delegates to the resolutions presented was an indication that both new and long-standing members of the association are committed to supporting continuing education programs for nurses and strengthening the voice of the professional association on a variety of broad health care issues. Collective approval was given to 11 resolutions. The subjects

ranged from actively improving the quality of psychological support for women having therapeutic abortions, pressing for government action on 'child-proof' bottle caps, and the further development of Home Care Programs to the licensure of all residences accepting persons who require level 1, 2, 3 and 4 care.

Joan Gilchrist, CNA president brought greetings from CNA and expressed approval of this year's theme. She also lauded the members for the resolutions, which "are crucial to nursing and to health care".

Newly elected members to the SRNA Council are: President-elect, **Mavis Kyle**, assistant professor, College of Nursing, University of Saskatchewan, Saskatoon; second vice-president, **Stella Dyck**, coordinator of the diploma nursing program, Kelsey Institute of Applied Arts and Sciences, Saskatoon. **Jean Keast**, director of nursing, Canora Hospital, Canora, Saskatchewan was re-elected as chairman, Committee on Nursing.

Theme address

Dr. Martin Collis, Department of Physical Education, University of Victoria, presented the keynote address "Fatness, Fitness and Fun." He emphasized, through a stimulating and clever use of pseudo country and western songs, the need for all of us to change our lifestyles.

Dr. Charles Messer, psychiatrist, Regina, discussed "How Not to Drive Yourself and the Other Person Crazy." Dr. Messer pointed out the need for self-understanding before we can understand our patients and the need to accept the other person as he is.

"Research in Nursing: Is it a legitimate pursuit?" was the topic discussed by **Dr. Beverlee Cox** of the University of British Columbia. The need for nurses to bridge the gap between service and education should be considered a priority for nursing research, she said. In particular, clinical nursing research was identified as a way of working together to solve common problems and to extend the boundaries of nursing knowledge.

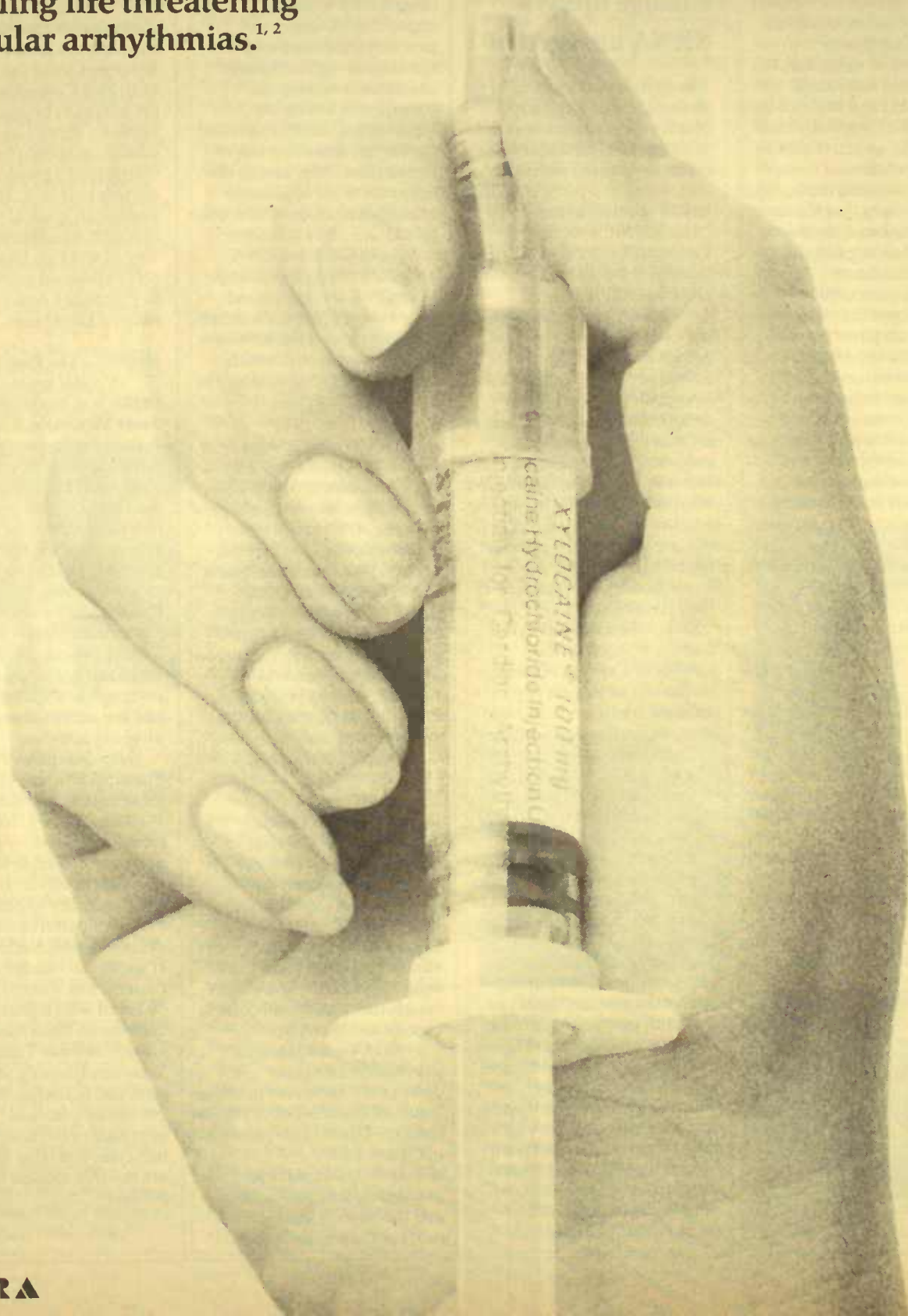
Health — The Possible Dream

A panel presentation on health was moderated by **Janet McKenzie**, instructor, Kelsey Institute of Applied Arts and Sciences, Saskatoon. **Honorable Ed Tchorzewski**, Saskatchewan minister of health, outlined the government support being given to preventive health care programs. **Donald Bailey**, College of Physical Education, University of Saskatchewan, Saskatoon, emphasized the changing perception of the human body and the accepted need for physical activity.

Dr. Josephine Flaherty, Principal Nursing Officer, Department of Health and Welfare, Ottawa, issued a tremendous challenge to nurses in changing their personal lifestyle. Everyone has the ability to change behavior patterns and to make decisions which affect health. If we do not change our pattern, she warned, we will be faced with higher health care costs. **Ilna Sarsfield**, Health Science Team Leader, Wascana Institute of Applied Arts and Sciences, Regina, presented practical approaches to changing lifestyles stressing that nurses are the role models for the public.

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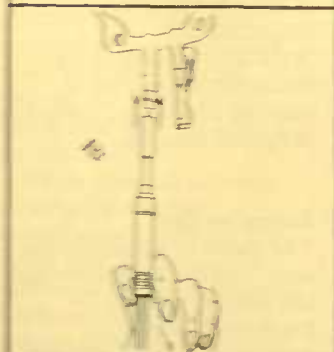
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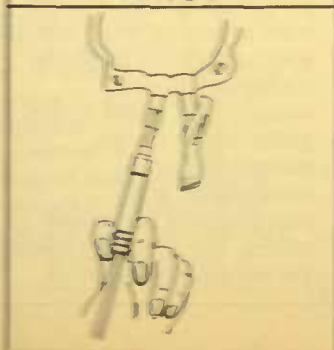
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INDICATIONS

Intravenous administration: The intravenous administration of Xylocaine is indicated in the treatment of ventricular tachycardia and runs of premature ventricular beats occurring during cardiac manipulation, such as surgery or catheterization, which may occur during acute myocardial infarction, digitalis toxicity, or other cardiac diseases.

CONTRAINDICATIONS

Xylocaine (lidocaine) is contraindicated in patients with known hypersensitivity to local anesthetics of the amide type, Adams Stokes syndrome, or severe degrees of unstable, atrio-ventricular or sino-ventricular block.

The safety of Xylocaine (lidocaine) in the treatment of arrhythmias in children has not been established.

WARNINGS

Constant ECG monitoring is essential for the proper administration of Xylocaine intravenously. Signs of excessive depression of cardiac conductivity, such as prolongation of PR interval and QRS complex, and the appearance of aggravation of arrhythmias, should be followed to prompt cessation of the intravenous infusion.

It is mandatory to have emergency resuscitative equipment and drugs immediately available to manage possible adverse reactions involving the cardiovascular, respiratory, or central nervous systems.

PRECAUTIONS

Intravenous administration of Xylocaine is sometimes accompanied by a hypotensive response, and, in overdose, this may be precipitous. For this reason, the intravenous dose should not exceed 100 mg in a single injection, and no more than 200-300 mg in a one hour period. See DOSAGE AND ADMINISTRATION.

PRECAUTIONS

Xylocaine should be used with caution in patients with bradycardia, severe digitalis intoxication, or first or second degree heart block. See CONTRAINDICATIONS AND WARNINGS. Caution should be employed in the repeated use of Xylocaine in patients with severe liver or renal disease, since possible accumulation of Xylocaine or its metabolites may lead to toxic phenomena. In unconscious patients, circulatory collapse should be watched for, since CNS effects may not be apparent as an initial manifestation of toxicity.

ADVERSE REACTIONS

Systemic reactions of the following types have been reported:

(1) Central Nervous System: dizziness, lightheadedness, drowsiness, apoplexy, euphoria, tremor, blurred or double vision, nausea and vomiting, sensations of heat, cold or numbness, twitching, tremor, convulsions, unconsciousness, and respiratory depression or arrest.

(2) Cardiovascular System: hypotension, cardiovascular collapse and bradycardia which may lead to cardiac arrest.

Adverse reactions tend to be dose-related. However, idiosyncratic reactions have been reported at low doses in some patients. Cross-sensitivity between Xylocaine and procainamide or Xylocaine and quinidine has not been reported.

SYMPTOMS AND TREATMENT OF OVERDOSEAGE

Symptoms of overdose or idiosyncratic reactions are as described under ADVERSE REACTIONS.

Use of the drug should be discontinued if severe reactions occur. In the event of circulatory collapse, emergency resuscitative measures, such as oxygen, vasopressor drugs or cardiac massage, should be instituted. Cardiac pacemaker and defibrillator should be readily available. For severe convulsions, small doses of an ultra-short acting barbiturate or a short acting muscle relaxant (if the patient is under anesthesia) may be used.

DOSAGE AND ADMINISTRATION

(a) **Single intravenous injection:** The usual dose is 50 to 100 mg administered under ECG and blood pressure monitoring. This dose may be administered at the rate of approximately 25 to 30 mg/min. Sufficient time should be allowed to enable a slow circulation to carry the drug to the site of action. If the initial injection of 50 to 100 mg does not produce a desired response, a second dose may be repeated after 10 minutes. **NO MORE THAN 200 TO 300 mg OF XYLLOCAINE SHOULD BE ADMINISTERED DURING A ONE HOUR PERIOD.**

(b) **Continuous intravenous infusion:** Following intravenous injection, Xylocaine may be administered by intravenous infusion at a rate of 0.2 mg/min (approximately 0.3-0.4 g/kg/min, or the average 70 kg patient) in those patients in whom the arrhythmias tend to recur, and who are incapable of receiving oral antiarrhythmic therapy.

Intravenous infusions of Xylocaine must be administered under constant ECG and blood pressure monitoring, and with meticulous regulation of infusion rate, in order to avoid potential overdose and toxicity.

Intravenous infusions should be terminated as soon as the patient's basic cardiac rhythm appears to be stable or as the earliest signs of toxicity. It should rarely be necessary to continue intravenous infusion beyond 24 hours. As soon as possible, and when indicated, patients should be changed to a oral antiarrhythmic agent for maintenance therapy.

Solutions for intravenous infusion may be prepared by the addition of one gram of Xylocaine (i.e. contents of 50 ml single-use vial, or contents of 5 ml disposable transfer unit) to one liter of an appropriate infusion solution. Approximately a 0.2% solution will result from this procedure; that is, each ml will contain approximately 2 mg of Xylocaine.

AVAILABILITY: (a) **For single intravenous injection:** XYLLOCAINE® (lidocaine HCl) 2% solution in 5 ml ampoules, or XYLLOCAINE® (100 mg lidocaine HCl) (2% solution) in 5 ml pre-filled syringe. Each will contain drug, thus 25-50 ml will provide 50-100 mg.

(b) **For continuous intravenous infusion:** Add to 1 liter of appropriate diluent, such as 5% dextrose and water, the contents of XYLLOCAINE® (lidocaine HCl) 2% solution in 5 ml single-use vial, 5 mg/ml, or XYLLOCAINE® lidocaine ONE GRAM (lidocaine HCl) in 5 ml disposable transfer unit containing 20 mg/ml. Resultant concentration following dilution is approximately 0.2%, i.e. 2 mg/ml, will provide 0.2 mg/min.

Full prescribing information available on request.

References

1. Le, F.L., Wilkins, H.J., War, Capelle, E.J. and Durrer, D. N. Engl. J. Med. 291: 1226-1228, 1974.
2. Harrison, D.C. JAMA 238: 1272-1284, 1977.

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News

President issues fitness challenge to N.S. nurses

"Nurses, please care for yourself and join me in becoming a fit nurse" was the message delivered by newly elected president Marilyn Riley of Halifax to the Sixty-Ninth Annual Meeting of the Registered Nurses Association of Nova Scotia held in Yarmouth, June 1 and 2. She issued a personal plea to all members, active and non-practising, to take part in a year-long health campaign, which she called the "president's lifestyle project."

In her speech, Riley asked nurses what they were doing for themselves. "When you work an 8-hour or 12-hour shift do you make sure that you get away from the strain of the ward for a few minutes or do you fool yourself by grabbing a cup of coffee on the unit? Are you taking time for hobbies and recreation?"

She urged nurses to "make a plan for yourself for a change in, or maintenance of, your lifestyle which will promote your good health." For those who say that running, cycling, skiing or swimming are not for them, Riley emphasized that, "you can get fit and remain fit easily, enjoyably, and at no financial cost, simply by walking. You can begin by walking 10 or 15 minutes a day slowly, and gradually build up to a brisk walk for about one hour a day, five days a week."

Forms, giving guidelines for participation in the project were provided at the meeting for the 200 nurses in attendance, and will be available to all nurses in Nova Scotia. Nurses are asked on the form, to assess their present health status in relation to what they plan to

change, set a goal for their desired state and make a plan to meet the goal. They have one year to work on and implement their plan.

Gladys Smith, retiring president, urged nurses to become more vocal in their communities in relation to health care issues. "Even though the association membership is near the 7,000 mark," she said, "who will take us seriously if no one knows we're here?"

During Smith's two-year term of office, the association has:

- established a scholarship for nurses wishing to study at the master's and doctoral level;
- instituted a Quality Assurance program for nursing care;
- set up a system of approval of continuing education courses for credit units (CEU);
- included liability insurance coverage in registration fees.

Business

The first day of the two-day meeting was devoted to the business of the association. Standing committees within the association — nursing education, nursing service and social and economic welfare — presented their report to membership. Other committees, such as the task force on the prevention of child abuse, the research committee and others also had the opportunity to describe their work.

Shirley Campbell, chairman of the special committee on the needs of the aged reported that throughout the year the committee members had worked and would continue to work towards improving fire safety for senior citizens in housing complexes, nursing homes and hospitals.

Karen Olsen, president of the Student Nurses Association of Nova Scotia reported that efforts had been directed throughout the year to increasing student participation and to supporting the Kidney Foundation. The new president of SNANS, one of two provincial student nurses' associations in Canada, is Cynthia Barkhouse.

A special guest, Pauline Chartrand, nursing consultant of the Family Planning Division, Health and Welfare Canada told the meeting that grants and other financing methods are available to nurses across Canada who are interested in training sessions, workshops or demonstration projects that deal with family planning. Further information can be obtained by writing to her at the Brooke Claxton Building, Tunney's Pasture, Ottawa.

On Thursday afternoon, delegates approved a total of three resolutions by membership. The first resolution, calling for the establishment of a special committee to study the province's nursing act to determine what changes are required, drew strong comment from the audience. The act has not been revised since 1966 and the assembly agreed that "a need for change is evident." However, Margaret Bradley, parliamentarian for the meeting and assistant director of the School of Nursing at Dalhousie University cautioned the group that serious discussion should take place prior to having the act opened in the legislature since it involves considerable expense and allows anyone, not only nurses, to suggest changes in the nursing act.

Delegates also approved a resolution to have RNANS bring pressure on the

provincial government to implement a coordinated home care program and for the association to be involved in the nursing component of that program. The third resolution called for RNANS to look into basic nursing education programs (both two- and four-year) to identify problems that contribute to some new graduates being unable to assume team leader and ward responsibility upon employment.

A motion from the floor to support the Canadian Nurses Foundation with a \$3,000 scholarship was carried. Members also approved establishment of a new yearly scholarship worth at least \$3,000 for Nova Scotia nurses.

The new officers for the RNANS executive are: president; Marilyn Riley, coordinator of the degree course for registered nurses at Dalhousie University; 1st vice-president: Patricia Fraser, director of nursing, Kings County Rehabilitation Centre; 2nd vice-president: Jean Dobson, director of nursing, Kentville Hospital Association; 3rd vice-president: Jane Haliburton, director of nursing education, Yarmouth Regional Hospital.

Education Day

The theme of education day was "self-determination and the nursing process." Demonstrations, presentations and exhibits were presented by a variety of specialty groups including emergency nurses, occupational health nurses, public health nurses, obstetrical nurses, neurological and neurosurgical nurses and others. The voluntary role of the nursing profession in

Yarmouth's Well Woman and Health Awareness Clinic (see CNJ, August, 1977) was also discussed, with a view to assisting other nurses in establishing similar clinics in other areas of the province.

Three outstanding nurses were honored with life memberships in the RNANS. They were: Frances Moss of Halifax, Dorothy Allen of Yarmouth and Vera MacKinnon of Antigonish. Frances Moss, retiring from her position as registrar of the association was also honored by a motion, passed by the assembly, to name the new yearly scholarship "The Frances MacDonald Moss Scholarship."

N.S. tests nurses' attitudes

The Special Committee on Nursing Research of the Registered Nurses Association of Nova Scotia carried out a unique project at the RNANS annual meeting held June 1 and 2 in Yarmouth. The purpose of the project was to increase the interest of nurses in research dealing with the practical problems of nursing and to demonstrate that "research is for everyone."

More than 200 nurses attending the meeting received a questionnaire that assessed the attitudes and practices of nurses in handling physician's verbal orders, a reported difficulty in hospital nursing services. The results of the 11 questions in the survey were delivered to the meeting by Ruth MacKay, chairperson of the Special Committee on Nursing Research and a professor at Dalhousie University. The relatively short time (one half day) for collection and

tabulation of the results further demonstrated that some research can be relatively simple, using skills which are not complicated and can be learned in a short time.

In her discussion, MacKay stated that 161 nurses had responded to the questionnaire, two-thirds of whom practice in a hospital setting. Approximately one-third of the nurses indicated that they had not seen an agency policy dealing with how to handle physicians' orders. Nurses were divided on whether or not they should accept verbal orders. Half of them felt they should go along with agency policy while another third felt it should be up to the individual nurse to decide whether to accept the verbal orders of a physician. Fifteen percent of the nurses felt that agency policies did not apply to them; 16 percent were willing to accept verbal orders from another nurse. Although many nurses were informed about policy and usually followed it, a sizable number stated that they did not.

MacKay summed up by saying that two implications can be drawn from the study: (1) nurses need to be oriented to agency policy (2) nurses need further reinforcement of the legal implications of acting without written orders.

In a later interview, MacKay stated that the research committee will be travelling to four or five different areas in Nova Scotia over the next year to give workshops in research methods.



Some 800 Ontario nurses stretched and twisted through a series of "health breaks" during this year's annual meeting of the Registered Nurses Association of Ontario in Toronto. The on-the-spot exercises were led by Patricia Kurki, one of 22 nurse teachers who participated in the Health Promotion Program sponsored last year by the Canadian Nurses Association. Guest speakers at the meeting included Thomas Langan, professor of philosophy at the University of Toronto, and Regina M. Bohn Browne, professor in the Faculty of Nursing at McMaster University.



The Canadian Nurses Foundation has announced the winner of its recent contest to design a new logo for the association. Above, Ottawa artist, Ian Roberts, (right) who designed the winning logo, receives a cheque for \$200 from CNF assistant secretary-treasurer, Eileen Mountain. Also attending the presentation was the president of the graphic arts firm where Roberts is employed, Don Williams.

News

"Prepared to care," Alberta nurses kick off province-wide campaign

Alberta nurses, now celebrating "their year" in that province, received a challenge to look at where they stand on the question of human rights within the health care system at their recent annual meeting.

Close to 400 nurses attended the three-day meeting (the 61st annual convention) of the Alberta Association of Registered Nurses in Edmonton May 3, 4 and 5. A kickoff breakfast on the first morning set the stage for the discussion that followed and marked the official opening of "The Year of the Nurse," dedicated, according to president Valerie Ayris, to "the nurse who doesn't fit the mold, who wears blue jeans or whatever, and works in a setting other than a hospital."

Patterned after the 1978 Year of the Nurse campaign sponsored by the American Nurses Association and still running in the U.S., the Alberta program is intended to serve the dual purpose of 1. informing the Alberta public about the changing and expanding role of the nurse in today's society, and

2. inspiring in nurses a renewed pride in their profession and increased interest in professional development.



Keynote speaker, Robert Cooper, host of the CBC TV "Ombudsman" show, noted that the theme of the Year of the Nurse is "prepared to care" and expressed his conviction that "the only way we will ever have good health care is if you *do* care."

He challenged the nurses in his audience to accept their "pivotal role" in providing consumers with the information they need to cope with the bureaucracies, special interests and securities that are part of the health care system. "Nurses," he said "can play an advocacy role that will give patients someone to represent them, to take risks for them and to make effective use of the media on their behalf. They can also add a significant measure of flexibility and sensitivity to the operations of the health care system."

In a follow-up address on the nurse as a consumer advocate, research associate Jan Storch, indicated that there are approximately a dozen patient representatives working out of hospitals in Canada now and urged nurses to welcome the emergence of



this category of health care specialist. Nurses, she pointed out, are well suited to the ombudsman role, providing they are willing to obtain the additional education they need and to function outside the nursing department within the hospital.

Storch, who is with the Division of Health Services Administration of the University of Alberta, suggested that nurses increase their effectiveness as patient advocates by accepting the need for professional growth and development through reading, inservice and continuing education, by becoming more aware of patient rights and by developing self-confidence in the advocacy role.

Patient rights

Six concurrent sessions on two afternoons of the convention offered delegates the opportunity to select special aspects of patient rights for closer scrutiny and discussion. Concerns covered in these sessions included caring for the rape victim, crosscultural nursing, the rights of minors, the abortion question, a patient's right to privacy, and long-term care.

Among these speakers was Miriam Ross, a Nova Scotia nurse who has practiced in many countries around the world and is currently completing Doctoral Studies in Anthropology at the

University of Washington in Seattle, Washington. Ross reminded nurses that "it is within the context of his cultural beliefs that a person reacts to health care" and, similarly, "unless nurses are aware that their own notions of caring are culturally defined, their actions may not be at all appropriate." She urged nurses to recognize and understand the ethnicity of their patients and the effect this has on the way the patient responds to everything from hospital food to efforts to make him or her comfortable.

"Surrendering your privacy for an Ident-a-band" was the title of Dr. Dorothy Smith's address. A professor of nursing at Rutgers University in New Jersey, she commented that "nurses' rights to privacy are transgressed daily" and speculated that this lack of concern for their own rights may make nurses less aware of the needs of their patients for privacy.

She suggested that nurses could take steps to safeguard the rights of patients to privacy by being more careful in their handling of charts and records and by creating opportunities for patients to be alone from time to time.

Interest groups

A total of twelve special interest groups sponsored concurrent presentations on the final morning of the convention. Among the groups represented were: community health nurses, directors of nursing and inservice education, emergency nurses, infection control nurses, mental health nurses, neurological and neurosurgical nurses, occupational health nurses, operating room nurses, orthopedic nurses, respiratory nurses and nurses with a



Nurse of the Year, Shirley Morie, receives award from the Hon. Justice Tevie H. Miller



Honorary member Fran Moore

special interest in fitness and research.

The closing address of the convention was delivered by Edward W. Keyserlingk, project coordinator with the Law Reform Commission in Ottawa. He described the commission as endeavoring to meet the challenge of finding a way to make the law relate more closely to reality and urged members of the health professions to let members of the public and legislators in on changes that are taking place in areas such as professional roles and relationships between the members of the health team.

U of A Scholarship

The University of Alberta Hospital Board is once more seeking applicants for its \$1,000 graduate scholarship in recognition of the 50th anniversary of its school of nursing.

The scholarship will be awarded to a graduate of the University of Alberta Hospital school of nursing who has been accepted in a university program for advanced education related to nursing at the baccalaureate, master's or doctoral level.

Applications must be submitted to the vice-president-nursing, University of Alberta Hospital, 112 Street and 83 Avenue, Edmonton, Alta., T6G 2B7, before June 30.

Winds of change blow for New Brunswick nurses

New Brunswick nurses need to take a look at where nursing is headed in their province and to actively participate in initiating change within the health care system. This message came from Judith Oulton, president of the 7,000-member New Brunswick Association of Registered Nurses during the opening ceremonies of the 62nd annual meeting of the NBARN. The meeting was held in Saint John on May 30, 31 and June 1.

Oulton warned the more than 200 nurses in attendance that "there are many factors at play at the government level that could have a profound effect on the direction of nursing." She stated that the recent *Task Force Report on New Brunswick Health Care* "appears to be continuing the status quo of acute-care, physician-directed health care. We realize that there is a great need to place more emphasis on prevention to defray health costs. We also recognize that nurses have the expertise to provide preventative care..."

"We must take positive assertive action to make our capabilities known to the government and insure their utilization."

Speaking at a time when the New Brunswick government is conducting a reevaluation of the health care system, studying health disciplines legislation and contemplating the closure of some diploma schools of nursing, Oulton asked nurses to take an active part in influencing the direction that nursing will take.

She suggested that giving strong support to the

Association through involvement at the local chapter level is one way for all nurses in the province to communicate their concerns and to actively participate in initiating change.

Addressing the assembly on Wednesday morning, Joan Gilchrist, president of the Canadian Nurses Association again encouraged New Brunswick nurses to 'dialogue' with the government concerning health care, acute care and extended care facilities.

"Quite clearly the time is now for the nurses of Canada to assume broader functions and responsibilities and to use a good deal of innovation and imagination in making changes which will have an effect upon

the health of our citizens."

She warned, however, that the apathy and complacency that has seemingly settled on the profession must be replaced with a time of renewal and commitment to change. "A profession that does not changes goes into dry rot ... We need to act in concert and after deliberations and the democratic process, speak as one undivided voice," she said.

Keynote address

The keynote address given by Dr. Margaret Scott Wright, professor and director of Dalhousie University's school of nursing in Halifax centered on this year's theme, "Nurse, would you dare to be a

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News

NBARN (cont'd)

patient?" Her speech, entitled "Respect: a two way street," was a direct appeal to the nursing profession to critically evaluate whether it is doing an effective job in meeting the health needs of clients and to consider the position of the profession in society.

She pointed out that "nurses have always had an awareness of the need to respect clients and patients" ... but that "the need for nurses to sense a reciprocal feeling of respect from clients and patients has not been given a great deal of attention." The establishment of patient committees and action groups seem to indicate "some lack of respect for the care provided by the various health professions, including nurses," she said.

She warned nurses that the professional image of nursing in society at large is "far from satisfactory and gives much cause for concern."

"A good example of this state of affairs was apparent in early April 1978 on the CBC "National" news program when for 4 or 5 consecutive nights various commentators were discussing the escalating cost of health care in Canada. As usual the word 'nurse' barely crossed the lips of the media men ..."

Dr. Scott Wright went on to point out that within the health care institutions themselves, nurses are not always in full control of the quality of care that can and should be delivered.

"Nowadays, most nurses are employed by the director of nursing service ... But what is the status of the director? Does she or he, as the major employer of professional expertise, have direct access to the places and meetings where decisions are made, or to consultation on an equal

basis with the chief executive officer and the finance officer? If not, how can anyone be sure to what extent ... (there is) adequate staffing with personnel of the right quality and experience? I suggest that unless senior nursing administrators can function as equals with their peers the prerequisites for developing respect as a two way street will remain inadequate."

In a large part, the problem is a result of nursing being 'invisible'. "In most countries, the voice of nursing is still very inadequately represented in the decision-making roles of federal, provincial or national civil services, and not surprisingly few nurses are appointed to other boards or executive positions in the land."

"They hear or see too little of us in places where decisions are made about the standards and quality of health care."

In responding to the question "Nurse would you dare to be a patient," Dr. Scott Wright concluded that until the quality of nursing care is controlled by nurses, who are after all the providers of care, then, she would be wary of becoming a patient.

To end the day's events, the topic: "Resolved that nurses are the only protectors of patients' rights" was hotly debated. Taking the affirmative stand was Evelyn Schaller, head nurse from Halifax, N.S. and Sandy Fudge, staff nurse in Saint John. Cheryl Doiron, student at Ottawa University's school of health administration and Shirley Martin, staff nurse in Saint John defended the negative view.

Papers and Business

Eight 3-minute position papers dealing with the theme "Nurse, would you dare to be a patient" were presented on baccalaureate nursing

education, diploma nursing education, nursing practice, public health nursing, nursing unit administration, geriatric nursing, the department of health and patients' rights. Audience reactions followed each position paper.

During the business sessions of the meeting, a number of resolutions by membership were passed dealing with subjects that ranged from investigating ways of providing yearly financial assistance to chapters, reviewing the process for the election of officers to promoting an increase in the ratio of registered nurses to nursing assistants.

In addition, members also approved a resolution that NBARN again urge the government to enact and implement laws making the reporting of child abuse mandatory. New Brunswick is one of two provinces in Canada that does not as yet have this legislation.

A special life membership to the NBARN was awarded to Margaret MacLachlan as a tribute for her contributions to nursing at the provincial, national and international level.

Spotlight on Cardiology

Over 500 nurses from all across Canada met in Toronto in late May for Cardiology '78, the fifth annual advanced intensive care seminar to be sponsored by the Health Sciences Division of Toronto's Humber College.

The two-day educational seminar was well-designed to meet the educational needs of nurses working in intensive care and featured a number of speakers that succeeded in challenging an enthusiastic audience. Topics discussed range from the interpretation

of cardiac arrhythmias to surgical treatment of aneurysms. Afternoon workshops permitted smaller groups of nurses to meet and discuss areas of specific interest.

Among the afternoon options presented were:

- a discussion on acid-base disturbances led by Gillian Bradbury, assistant head nurse of the respiratory care unit at Toronto General Hospital;
- a discussion of pediatric resuscitation led by Dr. John Edmonds and Donald Parks, R.N. of the Hospital for Sick Children in Toronto that stressed the differences between pediatric and adult resuscitation;
- a talk about an integrated diagnostic approach to chest pain by Marina Heidman, coordinator of the coronary care nursing program at Humber College and Dr. Donald Levene of Sunnybrook Medical Centre and the University of Toronto that outlined the many possible causes of chest pain. Nurses attending were given an opportunity to discuss case studies of patients who presented with chest pain in hospital situations.

Dr. Leo Shamroth, chief physician of Baraquinanath Hospital and Professor of Medicine at the University of Witwatersrand in Johannesburg, South Africa, talked to the delegates about radiological pointers for the cardiac nurse, showing the group how to identify pathological patterns in chest x-rays. Dr. Shamroth also led the pre-cardiology workshop, a two-day program on concepts of electrocardiography and arrhythmia interpretation that preceded the seminar itself. Three hundred and fifty nurses attended the pre-cardiology workshop.

Frankly Speaking

This month, two nurse commentators, each with a slightly different perspective on a problem that concerns us all, share our Frankly Speaking platform.

Editor's note:

Today, the effects of the shrinking health dollar confront, confuse and frustrate nurses at every turn. Staff cuts, increased workloads, greater reliance on part-time or inadequately trained help are constant reminders that we live in an age that is beginning to come to terms with the realities of limits to economic growth — finite and diminishing resources.

The result, as we know all too well by now, is that more and more frequently we find ourselves uncomfortably aware as we finish a day's work that the care we provided was less than optimal.

"Nurses," as Marie Campbell observes, "are being asked to make up with extra work for the difference between the level of care Canadians expect to receive, and what is provided for in health care budgets."

"Caught in this dilemma, we need to be able to distinguish between our own failures and those imposed on us by our working conditions and the economic context of the health care system. This is an important step towards learning how to work effectively in these difficult times. It calls for a shift in how we think about our work. We need to look at how nursing is related to the larger system of which it is a part, and how our work and our worklives are shaped by that relation."

What are some of the reasons behind the cutbacks and restraints? Author Jannice Dick describes what has happened to health care costs in recent years and has some suggestions to make about what nurses can do to prevent themselves from becoming the economic "whipping boy" of the health system.

Photo courtesy of Vancouver General Hospital.



Frankly Speaking

Economics

nursing's friend or foe ?

Jannice A.M. Dick

In order to grasp what has happened to health care costs over the past 20 years or so, and the magnitude of the problem facing us today, it is necessary only to realize two things. The first is the fact that financial transactions involving health care now account for approximately eight percent of the Canadian Gross National Product (7.4 per cent in 1975)¹; twenty-four years ago health care costs accounted for only one per cent of the Canadian GNP.² If present trends continue, health costs might well amount to ten per cent of the total GNP by the 1980's. The second fact is that provincial governments, the big spenders in the health care field, presently assign between one quarter and one third of their total budgets to health care costs. Ten years ago, health care absorbed only about one dollar in ten, or ten per cent of provincial budgets.³ The reasons behind such startling increases in health spending are not hard to find and can be explained in the light of the fundamental economic theory of supply and demand.

Demand

Three factors have contributed to an increase in *demand* for health care; these are:

- Population increases in Canada and changes in demographic structure. An increasing number of people are reaching old age and these consumers of health services require more, and a different kind of health care.
- Third party payment system in Canada (Medi-care). This is one of the most important factors contributing to cost inflation in health care services.

Today, the public is aware of the capabilities of the health care delivery system and expects and demands the best from it. This has contributed to the current feeling that good health care is a right as opposed to a privilege. What is too often forgotten, however, is that someone pays the price, whether it is government, employers, unions or consumers. In the Canadian system, third party payment hides the true cost of health care from the consumer. This leads to lack of incentives for cost-saving on the part of both the consumer and the primary decision maker in the health care system, the physician.

- An increase in the Canadian standard of living. The higher standard of living that many Canadians now enjoy has resulted in an increased demand for health care services, including many of the "goodies" associated with affluence, for example cosmetic surgery.

Supply

Historically, the factors that contribute to the *supply* of health care have been related to shortages:

- shortages of physicians, nurses and other medical personnel;
- shortages of hospital and long-term care facilities;
- shortages of educational resources and facilities to prepare the manpower required in the health field;
- shortages of community and preventive medicine programs.

These shortages in the supply of health care services exemplify the problem of trying to keep up with the tremendous demand. Initially, governments attempted to keep pace by increasing monies spent in all of the above areas. With the introduction of third party payment, utilization of health care services increased so much that it became evident that the price was simply too high.⁴ Now many questions are being asked:

- Are the results of such large dollar expenditures justifiable?
- Do we have a healthier population as a result of increased expenditures?
- Have health services reduced suffering or have they just prolonged life?⁵

The response of most provincial governments to the inflation of health care costs has been to enforce cutbacks in spending or, at least, to hold the line on spending in an attempt to realize a more efficient health care delivery system. When this happens the health professional group that is most immediately and directly affected by a reduction in spending, is nursing. Nurses know that the end result of the introduction of cutbacks is not a more efficient system but, instead, an increase in the frustrations of their everyday worklife. It is this fact that lies at the root of the dilemma of many nurses today: they realize that there is more work to be done now than ever before and, at the same time, there are fewer people to do it.

In the battle to get a fair share of the shrinking health dollar and thus avoid a decreased standard of care, nursing must mobilize the convincing machinery of indisputable facts. We must keep records to prove the contributions nursing makes to the health of Canadian. We can then use these facts to assist administrators of funding agencies in making decisions on how the health dollar will be spent.

The practising nurse can gather invaluable data in whatever field she is presently employed. Three examples spring to mind:

- **An ICU nurse intervenes when a life-threatening arrhythmia causes a monitor to alarm.** Quickly she calls the "99" alarm and defibrillates the patient's heart. The heart rate returns to a normal

rhythm. Her salary? Approximately \$7.00 per hour, a small price to pay for the life of a patient who can return to the community as a contributing member of society.

- **A community nurse makes five visits to an elderly, newly diagnosed, diabetic patient who requires supervision in giving himself insulin as well as an explanation of the diet he should follow.** Suppose each visit costs \$15.00. The total cost of these visits would be \$75.00, a small price to pay in relation to the suffering endured by the patient and the cost of hospitalization if the patient had made mistakes in diet or in insulin injection.

- **A public health nurse visits a family during a time of crisis.** She makes two visits and establishes referrals for family counseling. The cost of the two visits? Approximately \$30.00, a small price to pay in comparison to the costs of family dissolution and breakdown.

Based on our own experience, each of us can think of scores of similar examples; what we must learn to do is to appreciate the significance of these interactions with the sick and needy people who depend on us and remember to keep records of these patient encounters and of the results. Then, when the time comes to put the case for nursing to management, we will be able to explain what it is that nurses do in terms of the larger framework of the health care system.

The "quality of care, regardless of cost" approach, still prevalent in nursing thought, is no longer accepted by funding agencies. The reality of our times is an economy which currently exhibits limited growth and has finite and diminishing resources. A more efficient nursing care delivery system can be realized but nursing must justify with facts its invaluable contribution to the health of Canadians.

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Jannice A.M. Dick, author of "Economics — Nursing's Friend or Foe?", is on leave-of-absence from St. Boniface General Hospital in Manitoba while she is completing her Bachelor of Arts (Economics). At St. Boniface she is clinical nursing head of ICU's. A graduate of Ottawa Civic Hospital and Dalhousie University, she has been a teacher of nursing at Victoria Public Hospital in Fredericton, N.B. and at Toronto Western Hospital, Atkinson School of Nursing.

Frankly Speaking

What Price Cost Cutting?

Marie Campbell

It is my contention that nursing care is suffering as a result of the health care system, which organizes and pays for the work that nurses do, becoming increasingly business-oriented. When nurses think about how hospitals are organized, for example, we think in terms of the vocabulary and ideas provided by the hospital administration for the purpose of management. Nurses who act in "managed" institutions have no choice but to use organizational concepts in thinking about their work because the organization runs on these concepts. Our work has to fit into this frame.

What happens, then, when hospital and public health budgets are drastically curtailed, as they have been recently? For one thing, procedures that we used to think of as essential to good nursing care are often skipped these days as we find ourselves with too little time and not enough stamina to finish even the necessary routines and to cope with any emergencies that crop up. Management is thinking in terms of "productivity" and "efficiency," getting more work out of fewer employees, but we know that when the methods that were developed in industry are applied to nursing, the result is likely to be a deterioration in patient care.¹ What are the organizational concepts on which efficiency measures are based? How do they determine our working conditions? Why is it that implementation of these concepts is making it harder and harder for nurses to do a good job these days?

Organizational concepts

What follows are two examples of how organizational concepts shape the way that nurses think and the work that we do. The first concerns the way in

which the concept "problem-oriented" organizes the way in which a nurse thinks about health and illness.

When a nurse uses this concept in its organizational form she must sort and classify what is said and done during her interaction with the patient into something called a "problem." Either that or spend some time afterwards reconstructing the situation to fit the problem-oriented format. This structures the nurse-patient relationship and helps the nurse decide what to pay attention to, what to overlook or refrain from talking about. Use of this concept has been seen as an aid to health-care workers' memories; it can also be used for checking on the adequacy of the care given, since record-keeping based on the problem-oriented concept is directly adaptable for computerized accounting of what has been recorded.

Another example is "patient classification." This concept requires nurses to think about sick and convalescing people in terms of categories. Patients are slotted into categories of required nursing care by predictions based on information about a few of their more obvious needs such as: "Can they bathe themselves or do they need help?" "Do they get out of bed by themselves or with assistance?" Although the predictions are approximate and the information gathered reflects only some of a nurse's responsibilities for her patients, this procedure determines the care she gives. It ties a nurse to a workload assignment which constrains her choices about what she can do for an individual patient during her work period.

Sometimes nurses may want to act differently from what these organizational practices allow. But what nurses *think*, if it is outside the organizational forms isn't considered in management decision making. What nurses *say* is not heard; decisions are made on the basis of information documented according to the categories and concepts provided by management.

How is it, then, that this is considered the "right" way to organize nursing? Where do these management ideas come from? Why have they become the dominant ideas in hospital organization?

The ideas of power

The concepts which govern our society and its institutions are created and taught in educational settings. Business, government and professional leaders get their preparation in these settings and develop shared understandings. Advanced nursing courses, as well as hospital administration courses provide the concepts through which leaders in these fields come to understand what is important to the organization of health care. Nurses learn, for instance, about the necessity of presenting their ideas in statistical form, and of "documenting" their concerns rather than talking about them as experienced. People who do not use these "authorized" forms of knowledge are not listened to in meetings, planning sessions and so on. Unfortunately, this "authorized" knowledge does not always present a correct picture. Its authority based, on questionable "scientific objectivity," actually comes from the power that certain people have to dominate the centers where intellectual work is done and ideas disseminated.² University departments, for example, can control the kind of work that is done in them simply by controlling who is hired and who has tenure.

Historically, the people in these powerful positions have been men. Women have only recently been admitted to the circles where ideas originate and they are admitted now only as long as they conform to certain recognized criteria. They are hired largely in non-influential positions and

not in faculties such as law or commerce which train people for managerial and governing positions.³ Women are therefore excluded from occupying positions in which innovative thinking is done and policy developed. Similarly, priorities for authorized information-gathering are developed by men in management positions. There is a "break" between the daily experience of these men (in their offices) and the women health workers (who interact with sick and needy people). This is not just because one group is predominantly male and the other predominantly female, although sex-role training does contribute to how people "see" different things in the world.

Rather it is because their respective positions in their organizations require them to be concerned about different issues, to be specific — costs vs. human needs. Obviously both costs and human needs must be considered in hospital management and health care planning. The purpose of processing what nurses know through authorized forms is to turn it into information about costs for management use. This distorts not only the information but eventually what nurses are allowed to do in their work.

Management priorities

In hospitals and public health agencies, as in industry, management innovations are designed to increase productivity (a certain amount of work being accomplished by fewer workers, or in less time than previously) and efficiency (the worker increasing the ratio of useful work to the amount of time expended). In industry, this is how it happens. The work previously done by skilled craftsmen is broken down into discrete operations and assigned to a number of workers whose coordination becomes a management responsibility. This responsibility is frequently incorporated into automatic machinery

which sets the pace of work and eliminates the need for a worker to know how it all goes together, as the skilled craftsman did. The job that once required a skilled worker's competence can thus be done faster by unskilled, cheaper labor — machine-tenders or operatives. The demand for skilled craftsmen declines and eventually these workers cannot find jobs that pay what their skills had previously been worth. They are reduced to taking work as operatives themselves, at the going rate for unskilled work. The next generation of workers is not trained to do competent craft work and thus the labor force becomes increasingly vulnerable to the vagaries of the market.⁴

In nursing, the thrust of modern management is towards defining nursing functions and controlling the number and type of workers assigned to do a defined quantity of work. The work process itself, (care of sick people), cannot be split and put on an assembly line as in industry but it can be treated that way on paper. Workload assignment is done on paper, by management personnel acting on information gathered in hospital wards by nursing staff. Decisions which individual nurses make at the bedside depend upon management decisions about how many nurses and what kind of nurses are assigned to specific patients.

What happens, in practice, is that, increasingly, the smallest possible number of highly skilled nurses is assigned to a ward. Reliance is then placed on tighter control of the work of staff who have less formal training. This management function is handled in various ways, most often by use of objective evaluation procedures which rate a nurse's performance of activities designated as being a demonstration of her competence. Besides being seen as a

fair evaluation tool, this procedure is aimed at the standardization of nursing behavior. Using it, a few trained management nurses can regulate the practice of a large number of underlings with minimal personal contact. This, in itself, constitutes an efficiency measure, reducing the number of high-priced nurses needed. If evaluations are done frequently or on an irregular basis, nurses will be obliged to act in approved ways, at least where they are open to observation. In this way, use of nursing performance evaluations teaches nursing staff what behavior is approved. At best, however this is only a partial control over what nurses actually do, and not a reliable substitute for a competent, professional staff.

The future

The advantage of having a staff of less-skilled nurses is that they are cheaper than nurses with more preparation. Of course, nurses pay for this kind of efficiency measure. Recently we have seen widespread unemployment among registered nurses in Ontario, attributable partly to their replacement by RNA's,⁵ and in some hospitals in B.C. licensed practical nurses are being replaced by nurses' aides.⁶ The loss of jobs in the intermediate range of professional training (RN's and LPN's who now command a comfortable living wage) means that this large group of nurses will eventually be forced to take jobs which pay less and are open to competition from less-skilled workers. The number of highly specialized nursing jobs in a high salary range will remain relatively small and the long-term effect will be to depress the earnings of most nurses.

Frankly Speaking

Another effect of management methods aimed at productivity and efficiency is deterioration of patient care. Lowering the quality of the "product" in work involving human life cannot be equated with less stringent standards of, for example, automobile production, and therefore compensatory measures have been introduced. Clinical nurse specialists are quality control agents, demonstrating good patient care and trying to motivate staff who lack fundamental training and are overworked. But tighter control, more precise instructions and modelling of exemplary care cannot make up for the replacement of skilled professionals by nurses who have less training, less professional involvement and presumably less commitment to an institution which treats them like factory hands.

The biggest loser from these developments in health care organization and hospital management may well be the nursing profession itself. If the present trend continues, the profession will find itself divided into two segments whose interests are increasingly divergent. Nursing education will have to reflect this split since there will be a demand for only two types of nurses — those who are highly specialized, and those who are relatively unskilled. Much of the profession's research is already directed toward management concerns, bridging the knowledge gap between what nurses do and how it can be cost-accounted and controlled.

In the process, the profession's autonomy is eroded and nursing care suffers. Nurses are being blamed for much of the increased expenditure in health care and we are being made to

bear the burden of financial restraint. We shouldn't have to. Nurses deserve a good living wage, and patients deserve competent nursing care. Both are cheated by a system which increases a nurse's workload to the level of her endurance.

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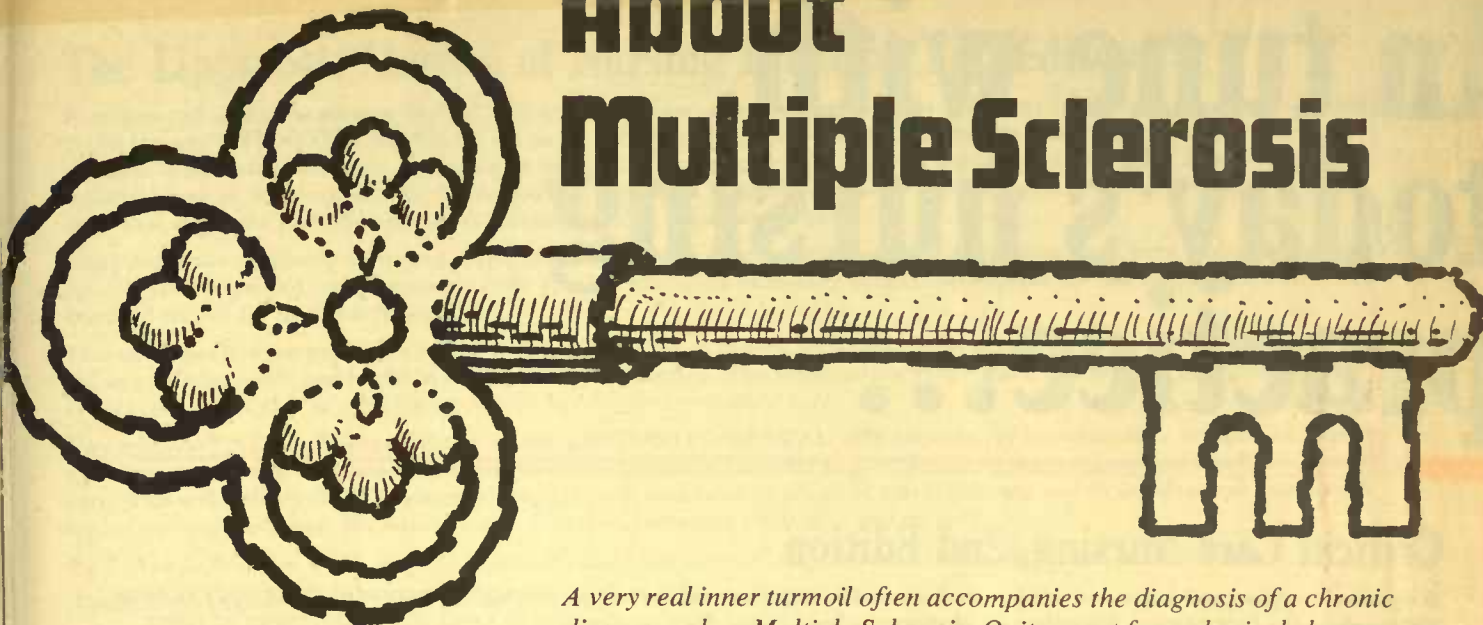
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About Multiple Sclerosis



A very real inner turmoil often accompanies the diagnosis of a chronic disease such as Multiple Sclerosis. Quite apart from physical changes your patient may well have to face a loss of employment, marital breakdown, social isolation and an almost inevitable depression. How can you help alleviate, if not prevent, some of the anxieties these patients face?

Noreen McNairn

The health professional, whether in an institution or in the community, must be prepared to act as a resource person for the patient. This can prove difficult when working with those who have Multiple Sclerosis because most information is scattered through texts and, in many cases, relevant material is made up of as yet unproved theories. If the disease process is an enigma to the trained professional, how much more confusing it must be to the newly diagnosed lay person.

As a community health nurse, a member of the Multiple Sclerosis Society, a liaison with an M.S. clinic and as coordinator of a long-term Home Care Program I am familiar with many of the problems faced by professionals when treating an M.S. patient. These problems are as individual as the people involved and yet many concerns are commonly expressed. Let's take a look at a few of them.

WHAT IS MULTIPLE SCLEROSIS?

M.S. is a disease primarily affecting young adults between the ages of 20 and 40. It is marked by sclerosis (hardening) occurring in sporadic patches throughout the brain and spinal cord. These areas harden as a result of inflammation in the connective tissue.

M.S. has no classic form but most patients who have had the illness for many years display the symptoms originally described by Jean Charcot in 1868 (known as "Charcot's triad");

- slow, scanning speech (slow enunciation with a tendency to hesitate at the beginning of a word or syllable)
- muscular intention tremor and loss of tonicity
- ocular abnormalities, especially nystagmus.¹

M.S. is a chronic, slowly progressive disease of the central nervous system. The disease can be recognized pathologically by the presence of numerous areas of demyelination and clinically by the numerous neurologic symptoms described by Charcot. All of these neurologic symptoms tend toward remission and exacerbation.²

WARNING SIGNS

Initially your patient may have sought medical aid for any one of a number of reasons often related to socially embarrassing situations. Before diagnosis your M.S. patient probably experienced;

- visual problems which appeared and disappeared seemingly with no pattern or predictability (this may have made such activities as driving a car particularly frightening and hazardous)
- a difficulty with coordination resulting in spilled food, dropped pencils and tripping over one's own feet
- inappropriate emotional responses (eg. laughing uncontrollably at a funeral)
- an increasing slowness and slurring of speech.

A definite diagnosis of M.S. can seldom be made at the time of the first attack; even exhaustive tests may offer

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insufficient data to be immediately conclusive. The whole process of diagnosis can take a considerable amount of time, as nurses we must be ready to support our patient throughout this experience.

WHAT CAUSES M.S.?

Numerous factors have been cited as *possible* causes of M.S. but the *definite* cause remains unknown. Extensive research into this disease is being carried out constantly.

Current theories suggest that M.S. may be the result of a virus contracted in childhood. The virus remains latent for 10-15 years and then begins to react with the nerve fibers, stripping them of their insulating myelin. If this is true then the symptoms would appear to be dependent upon whichever nerves are affected. But autopsies have found cerebral and spinal plaques in patients who displayed no symptoms of M.S. This suggests factors other than the demyelinating process must be present.³

High levels of gamma globulin in the cerebrospinal fluid of M.S. patients suggests an autoimmune reaction and therefore some form of inflammation.

There is a higher level of measles antibody in persons affected by M.S. than there is in the general population. Perhaps there is a relationship between a measles-type virus and the disease process.⁴

It is not known whether genetic factors play a role in the development of M.S. If there is a genetic influence it is considered recessive with low penetration.

M.S. occurs only rarely in the tropical regions of the world. It is characteristically a disease of cold, damp climates and can be aggravated by these conditions. The geographic areas of high risk are western Europe, Switzerland and countries to the north, the northern United States and southern Canada. The incidence of M.S. in Canada is 60/100,000.

HOW LONG WILL MY PATIENT LIVE?

Generally speaking your M.S. patient is likely to live a fairly long life. Symptoms will abate and recur with increasing frequency and severity each time for many years. Only very rarely does death occur due to plaque formations in one of the vital centers of the brain. Death for an M.S. patient is usually the result of an infection such as pneumonia or pyelitis which further weakens an already debilitated system. When M.S. patients

are treated with immunosuppressants the body defences are affected making them even more susceptible to infection.

No one can predict the course M.S. will take in any individual. Many people have five or more years between the temporary visual disturbance that is often their first noticeable symptom and any other sign of disability. For some people the disease process is full of exacerbations and remissions while others may stabilize after the initial exacerbation and never regress beyond this point. There is still another group of individuals who appear to steadily deteriorate with no remissions at all.⁵

WHAT CAUSES EXACERBATIONS OF M.S.?

Any alteration in the chemical composition of those body fluids which come into contact with the demyelinated nerve fibers can trigger an exacerbation. Any infection, medication, emotional stress, hormonal change or physical shock is a potential agent for exacerbating M.S. For this reason care must be taken to treat any urinary tract or upper respiratory infection promptly. M.S. patients must also think carefully about alternatives before undertaking any immunization program (eg. flu shots). If surgery, such as a hysterectomy, is necessary the danger lies not in the anesthetic but in the accompanying medications and the potential hormone imbalance that can result. Any prolonged period of inactivity may also be a factor contributing to exacerbation or a general regression in the patient's well-being because unused muscles are weaker muscles and weakness can easily lead to frustration and depression for your patient.

IS THERE A DRUG THERAPY PROGRAM TO TREAT M.S.?

There is no specific therapy for multiple sclerosis. Although many different treatments have been tried over the years none have proved effective in stopping or controlling the course of the disease. As a result care of the patient with M.S. is really a matter of dealing with the patient's current needs, of dealing with the symptoms during periods of exacerbation rather than treatment of the disease itself.

It is interesting to look at some of the theories that have been or are being tested:

Vitamins: especially B₁₂, B₁ and liver extract have been used. Since a deficiency of these vitamins deteriorates the health of the nerves perhaps a supplement would improve nerve health. **Nutritional Therapy:** High fat diets, low fat diets and specific brain lipid components such as cerebroside have all been tried. This was an attempt to increase the availability of the raw

materials which encourage myelin repair.

Intravenous Lyophilized Yeast Complex:

This is a European treatment which is still being tested. The theory is that the yeast complex will stimulate substances essential to the body's immune defences against viral, bacterial and toxic substances.

Right now steroids are used to combat inflammation present during exacerbations of M.S. Cortisone and corticotropin have proved temporarily beneficial but they have not worked to alter the ultimate course of the disease.⁷

Tranquilizers are sometimes necessary because of the psychological effects of M.S. as a chronic disease. Antispasmodics may also be indicated but they must be monitored carefully as they can weaken muscles.

MY PATIENT IS TRYING TO DENY HIS DISEASE

"I don't want anyone to find out that I have M.S."

Because M.S. patients are acutely aware of the social stigma that chronic illness can have this statement exemplifies a common attitude among those who have been newly diagnosed. Indeed for many patients this "denial" phase can continue for quite a long time.

Embarrassment about the "drunken" gait along with an increasingly apparent awkwardness can make your patients try to hide their symptoms. Often this serves only to make both their gait and awkwardness more evident as their tension increases. You must encourage your patient to be open and realistic about this disease, at the same time you have to realize how difficult this will be. Your patients will need both time and support before they can even begin to accept their condition.

HOW CAN I HELP MY PATIENT ADJUST?

Studies of patients with spinal cord injuries show that the unmarried young adult patient has the most difficulty adapting to the community after illness. Married adult males who had, before their illness, occupied a central role in the family and in employment adjusted more smoothly although they did experience difficulty adjusting to enforced role reversal. The best adjustment to disability was made by adult females who often experienced no specific difficulty; in most cases these women were able to take up their former positions as homemaker and therefore received a higher level of job satisfaction than did their male counterparts.⁸

It is important for us as health professionals to help our chronically ill patients stay in their own environment for as long as possible. The environment to which your patient returns from the hospital is very important; it will be

beneficial if there is understanding and acceptance on the part of the family; it will be most detrimental if these attitudes are not present. For this reason education of the community at large is essential if the M.S. patient is to have the opportunity to function as completely as possible within the confines of his disease.⁹

Your M.S. patients must be able to confide in their family doctor and should be encouraged to do so. In this way they can be referred to appropriate community agencies such as the Multiple Sclerosis Society. If your patient's disabilities progress beyond the capabilities of community resource people such as visiting nurses, physiotherapists, occupational therapists, and visiting homemakers then other facilities such as chronic care homes will have to be considered. It must be emphasized however that only a very small percentage of M.S. patients require institutionalization — most are able to continue functioning in their home environment.

WILL MY PATIENT BE ABLE TO CONTINUE WORKING?

This depends upon the nature of your patients' employment, their co-workers and their own personal attitudes. An assessment of the suitability of the worker to his or her environment can be done by an occupational therapist who can, in turn, make suggestions to your patient and to the employer. Should physical barriers or disabilities exist that are insoluble, agencies are available in most communities for vocational retraining and placement.

IS THERE A SPECIAL DIET M.S. PATIENTS SHOULD FOLLOW?

As with any chronically ill individual it is important for your M.S. patients to maintain their body at its maximum level of efficiency. Nutritionally this is handled

best by maintaining a well-balanced, normal diet. Too often food fads cause people to concentrate on one aspect of dietary intake (eg. protein or Vitamin B). This can result in vitamin deficiencies which add to the patient's problem rather than help alleviate it.

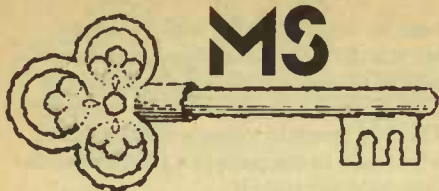
WHAT ABOUT AN EXERCISE PROGRAM?

Active exercise is important for the M.S. patient to maintain and even increase muscle strength but moderation is the key word here. Often fatigue can be even more damaging than inactivity. Your patient must learn to stop exercising before tiring. This can be a difficult skill to learn but it is absolutely essential to define the body's physical limits and avoid over-exertion. A physiotherapist can suggest a careful program, well-monitored and tailored to the needs of the individual. No one regimen is suited to all M.S. patients.

HOW WILL THE WEATHER AFFECT MY PATIENT?

It has been demonstrated that heat and humidity can cause weakness in the patient with M.S., therefore hot baths and showers should be avoided. An air conditioner may prove to be a worthwhile investment. Cold pack applications to muscles can decrease spasticity and increase strength but the effect is temporary; the improvements disappear as quickly as the body temperature rises.





WHY WON'T GLASSES HELP MY M.S. PATIENT'S EYES?

The diplopia and nystagmus of M.S. are usually unresponsive to correctional lenses but poor eyesight can be less of a problem if the doctor alternately blocks off one lens at a time with a plastic cover.¹⁰ As visual difficulties are often transitory there is little that can be done by symptomatic treatment. In spite of this your patient must be encouraged to have regular visual examinations to ensure that no treatable condition exists.

WILL MY PATIENT'S MARRIAGE BE AFFECTED?

There may be a decrease in the sensitivity of the erogenous areas. Your patient and his or her partner should be made aware of the other areas of the body that aid in the attainment of sexual gratification. It is equally important for both partners to be involved in this kind of discussion. The changing of sexual habits is a very personal thing and must be handled delicately.

Many marriages involving people affected by M.S. are very successful, but those whose foundation was shaky from the start often break up, if not actually, then at least emotionally. One British study showed that one-third of the M.S. patients involved were described by their families as having undergone marked personality changes as a result of CNS damage. The families found this the most difficult symptom to accept.¹¹ It is tremendously difficult for one partner to witness in the other the complete change in attitude and overall personality that can result from cerebral plaque formation. Marital counselors can help your patient and his or her spouse as they try to come to grips with the changes as they occur.

SHOULD MY M.S. PATIENT ALLOW HERSELF TO BECOME PREGNANT?

Because pregnancy is an acknowledged stress on the body, both physically and emotionally, and because stress is accepted as a precipitating factor in exacerbations of M.S., pregnancy could have an adverse effect on your patient.¹² Right now doctors are encouraging their female M.S. patients to wait at least five years after the appearance of their first symptoms before planning a pregnancy. This period of time serves as an indicator of the course of their disease. If it appears stormy and fraught with exacerbations, the recommendation would be to avoid conception. However, if her condition seems to stabilize then

pregnancy may be possible without adverse reaction. The main consideration for your M.S. patient, as far as family planning is concerned, should be her almost inevitable physical and possible mental deterioration. Prospective parents must consider the future of their offspring — where will their child go if Mom is no longer able to care for them.

HOW CAN I HELP MY PATIENT WITH BLADDER AND BOWEL CONTROL?

Poor sphincter control is a result of CNS plaque formation¹³ and therefore incontinence is a common embarrassment for M.S. patients. Regular voiding and strengthening of the pelvic floor muscles will often help relieve the problem. You can also help by making sure that the toilet or commode chair is readily accessible to your patient. Often even the addition of grab bars in the bathroom can make things easier.

Your M.S. patients must understand the dangers inherent in a reduction in their fluid intake as they may try to use this method to prevent accidents. The dangers of urinary tract infections must be stressed as must the importance of an adequate intake in stimulating sphincter control. If all else fails external collection devices for men and adult-size waterproof pants for women will assist your patient in overcoming social embarrassment.

Constipation can be another problem for the patient with M.S. The first step towards helping your patient deal with this is to assess the diet for bulk and adequate fluid intake. Suppositories are preferable to enemas in cases of extreme constipation because poor sphincter control and possible excoriation can occur when the patient is unable to retain fluid.

This article is not complete — no single paper could provide all the answers to all the questions that arise following the diagnosis of Multiple Sclerosis. But I have endeavored to provide the background information necessary for effective health teaching and nursing care. Your local chapter of the Multiple Sclerosis Society can provide both you and your patient with additional assistance.

Noreen McNairn, the author of *About Multiple Sclerosis . . .* graduated with a B.Sc.N. from McMaster University in 1958. After graduation she spent many years with the V.O.N. working as a staff nurse and later as a relief nurse. Noreen became Coordinator of a Chronic Program for Home Care in 1975. Her duties as program coordinator and her position as Community Liaison with the Multiple Sclerosis clinic at McMaster keep her busy now.

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RYTHMODAN: a new cardiac depressant

During the last year, a new cardiac depressant has been introduced to the Canadian drug market. The drug is called Rythmodan or disopyramide. The fact that it is available by prescription in an oral preparation but remains an investigational drug in its intravenous form* has made Rythmodan the subject of controversy and research. It is obviously important that nurses who will be giving the drug know something about its electrophysiological and hemodynamic properties.

Laura Worthington

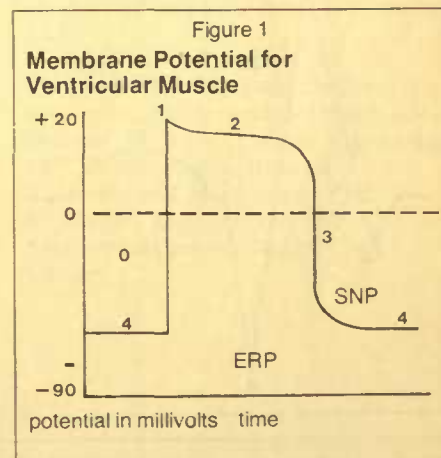
Rythmodan is classed as a cardiac depressant. As such, it joins the ranks of Xylocaine, Dilantin, Quinidine and Pronestyl as a medication capable of suppressing ectopic beats within the heart's conduction system. To adequately understand disopyramide's mechanism of action, it is necessary first of all:

- to review electrical activity in the cell, and
- to define the terms which will be used in discussing myocardial conductivity.

Electrical activity

Every cell in the body has the ability to generate an electrical potential. What does this mean? Electrical potential is a reflection of the electrical difference between the inside of the cell and the medium in which it rests. If this potential is measured during a contraction of the muscle fiber, each cell would generate a current similar to the one seen in Figure 1. An unexcited cell is said to be at *resting membrane potential* (RMP), commonly called phase 4. If we were to monitor this potential with an electrode, it would read -90 millivolts. In cells that have the ability to initiate depolarization of the muscle, there is a constant exchange of ions, particularly sodium and potassium, across the cell membrane. This causes the cell to become excited, and phase 0 is initiated.

Depolarization, phase 0, proceeds rapidly as the movement of ions causes the electrical potential to become more positive.



Threshold, the point at which a cell is capable of firing, is reached. The fiber achieves its action potential, +20 millivolts, and contracts. From this point, it is a downhill glide for the cell through phases 2 and 3, *repolarization*, until RMP is reached once more.

The process will repeat itself as often as the cell is motivated to fire by an outside stimulus, or as frequently as its own inherent rate will allow. The cell's inherent rate of firing is known as its

**As of May, 1978, Rythmodan is no longer an investigational drug.*

automaticity. The inherent rate of the sino-atrial node is about 75 per minute. Remember that normally, it is the sino-atrial (SA) node that sets the pace for the heart. Lower conduction centers, such as the atrio-ventricular (AV) node or the Purkinje fibers, have their own inherent rates — 60 for the former and 30-40 per minute for the latter. If the SA node fails, it is hoped that these lower centers will take over.

When thinking of a cell unit within the myocardium, it is necessary to realize that an "all or nothing" principle applies. Although we talk in terms of a single cell generating an electrical potential, it is the whole muscle mass that participates during a cardiac cycle. The phases of individual cellular excitability then can be compared with

the phases of a normal Q-R-S-T complex. (See Figure 2) Phase 0 or depolarization appears as the Q-R-S complex of a cardiac cycle. Phase 1 begins repolarization, a process which is continued through phase 3. You may notice in Figure 1 that repolarization slows during phase 2, often called the plateau, and speeds up during phase 3, a phenomenon referred to as accelerated depolarization. The T wave on electrocardiogram represents these stages of repolarization. Normally the time lapse between phase 1 and phase 4 when the cell is once more resting, is considered the *effective refractory period* (ERP). An impulse delivered to the cell during ERP will not be able to cause it to contract again. The telegraph lines are jammed and a new message cannot get through.

There is however, one important exception ... During the final slope of phase 3, there exists a *super normal* period. During this period, the cell mass, which is still repolarizing, can be motivated to fire if an ectopic stimulus is presented to it. Nurses working in critical care will recognize this situation as the R on T phenomenon. An ectopic beat (R wave) falls on the T wave of the previous cardiac cycle. In 50% of cases of R on T, the lethal arrhythmia — ventricular fibrillation — follows immediately, and all because of a short super normal period at the end of phase 3. (See Figure 3).

Rythmodan action

If you understand myocardial conductivity, it becomes easy to understand just how Rythmodan works on myocardial conduction fibers. One of this drug's major properties is that it decreases cellular *automaticity*, the ability of the membrane to achieve action potential and fire. In other words, Rythmodan prolongs phase 4. Recall that phase 4 is resting membrane potential, during which time the cell is normally quiet. If its duration is prolonged by Rythmodan, ectopic beats will not be able to excite the cell.

The *conduction velocity* of the electrical impulse is also *slowed* by

disopyramide. Conduction velocity is the speed with which an electrical impulse travels. To prolong it simply means that each beat takes longer to make its way through the heart's conduction system. Electrophysiologically, this lengthens both the time of depolarization (phase 0) and repolarization (phases 2 and 3). On a cardiac monitor, a widening Q-R-S and Q-T interval reflect this electrophysiologic change.

Finally, Rythmodan decreases ventricular *excitability*. Excitability is the strength of the external stimulus required to initiate depolarization, the Q-R-S complex. It is the "kick" that prompts the cell to fire. Disopyramide's action in decreasing excitability means that irritable ectopic ventricular foci, such as the type present after a myocardial infarction, will not be strong enough to interrupt the heart's normal rhythm.

Indications for use

Although Rythmodan is still being evaluated, it appears to have its greatest success in alleviating ventricular ectopic beats. In one study,¹ disopyramide was found to have a 22% success rate with atrial arrhythmias and an 87% conversion rate for ventricular beats. These beats included:

- premature ventricular contractions (PVC's): unifocal and multifocal
- ventricular tachycardia
- R on T phenomenon.

Disopyramide is proving particularly attractive as a means of controlling PVC's intractable to Xylocaine — the ever-present dilemma of critical care units.

Methods of administration

Rythmodan comes in 100 mg tablets for oral administration. A maximum plasma level is achieved in most patients in one hour, and the drug's half life is six hours. For this reason, the recommended oral dosage is 100 mg every six hours.² Some physicians feel that a loading dose of 200 mg p.o. is appropriate initially. Rythmodan has an advantage over Xylocaine in that it is readily absorbed by the gastrointestinal tract.

Figure 2
Membrane Potential and the Cardiac Cycle

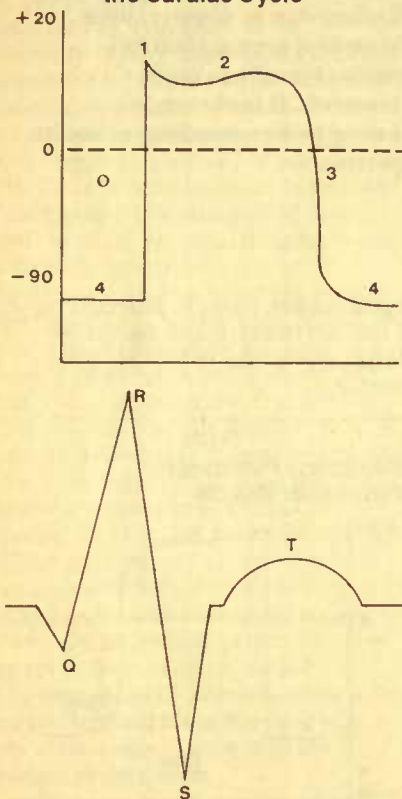
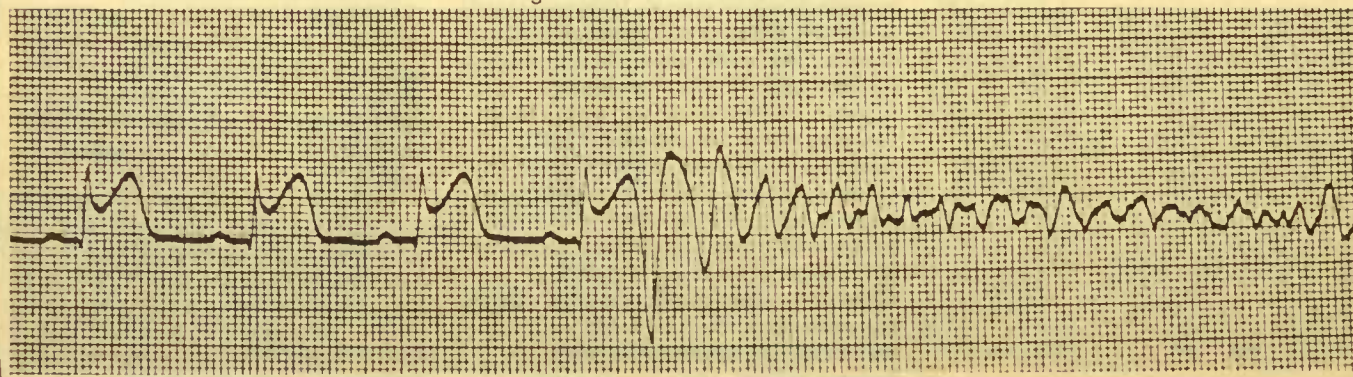


Figure 3 R on T Phenomenon



Intravenous administration of disopyramide is still at the investigational stage; in its intravenous form, it can be obtained only by certain physicians. Some teaching hospitals are using it intravenously. Table 1 is for the benefit of nurses working in settings where the drug is being used intravenously. Clearly Rythmodan cannot be given in a bolus form intravenously as Xylocaine can. In arrhythmias that require immediate termination, Xylocaine remains the drug of choice.

Table 1

Intravenous Dosage of Rythmodan³

Initial:	2 mg/kilogram in dextrose 5% and water over 15 minutes
To follow immediately:	2 mg/kilogram in dextrose 5% and water over 45 minutes
Maintenance:	0.4 mg/kilogram/hour in dextrose 5% and water times 24 hours or until improvement.

Note: Rythmodan I.V. is supplied in 50 mg ampoules.

Contraindications

Because of its ability to prolong conduction time, Rythmodan should not be used for patients who already have severe intra-ventricular conduction defects. Second and third degree heart block are also a contraindication to the use of the drug. Because of its ability to depress myocardial contractility, disopyramide should not be given to those who are suspected of heart failure or to those who have extensive myocardial disease. These conditions would only be enhanced by the drugs negative inotropic effect. If Rythmodan is being given to someone in borderline heart failure, it is recommended that the patient be digitalized first.

Disopyramide also possesses anticholinergic properties. Because of these effects, patients with glaucoma or urinary retention are not good candidates for the medication. Administration of Rythmodan to such patients will only serve to increase medical problems. For the same reason, patients in shock or renal failure may also experience negative hemodynamic effects if they take the drug.

Signs of overdose

If the patient is suffering from Rythmodan toxicity, his cardiac rhythm strip will reveal a widening Q-R-S complex which may progress to complete heart block and eventual cardiac standstill. The nurse should keep

a careful record of the width of the patient's Q-R-S complex if he is being monitored. If he is not on a cardiac monitor, an abrupt drop in his pulse to 30 or 40 per minute — the inherent rate of the ventricles — may indicate heart block.

Because of its negative inotropic effect, Rythmodan can initiate episodes of heart failure or pulmonary edema.⁴ It is an important nursing responsibility to assess left ventricular function while the patient is on disopyramide. Before the obvious signs of heart failure, pulmonary edema and rales, show themselves, the nurse may observe an increase in the patient's respiratory rate. This represents his attempt to "blow off" carbon dioxide. If this fails, the patient may have a change in his mentation, as CO₂ content in the blood increases. Often such patients express a feeling of apprehension. Eventually cyanosis will be evident in the nail beds, lips and ear lobes. If the patient is in an area where his left-sided heart pressures are being measured by a Swan-Ganz line, an elevation in wedge pressure above the patient's normal reading will reflect a failing ventricle.

Treatment

The primary treatment for Rythmodan toxicity lies in prevention. By using careful observation and closely monitoring the patient, the nurse may be able to pick up early signs of toxicity. Because the drug is new, certain physicians are not fully aware of the proper dosage. It is a nursing responsibility to see that the patient receives only the recommended doses of the drug.

If in spite of precautions the patient becomes toxic, Rythmodan should be discontinued. Instances of heart block must be treated with the insertion of a temporary pacemaker. If the patient continues to have arrhythmias, it is not recommended that another anti-arrhythmic be given right away, as it may also act as a cardiac depressant. Because both have negative inotropic effects, the new drug may further inhibit cardiac contractility. A heightened anticholinergic response to disopyramide can be offset by administering cholinergics such as neostigmine and physostigmine.

While Rythmodan is a newcomer among the cardiac depressants, it possesses attributes that seem to assure it some permanence on the Canadian drug scene. Its ability to convert PVC's intractable to Xylocaine, as well as its oral availability, make it an important alternative in long-term suppression of ventricular arrhythmias. Because it is a new drug, it is important that all medical workers who prescribe, handle and distribute the drug be adequately aware of its effects.

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Psychosocial Aspects of the CANCER Experience

Pamela Gaherin Watson

Of all the diseases known to man, cancer is probably the most feared. Regardless of one's intellectual ability, educational background or social standing, no other diagnosis is capable of producing the terror stricken response that cancer evokes.

Cancer is not a single disease entity; it is a large group of diseases characterized by uncontrolled cellular proliferation. According to the Canadian Cancer Society, one person in six will have some form of cancer in his lifetime. Clearly, cancer rehabilitation involves a large number of clients many of whom will only be able to make limited rehabilitation gains. The nurse is called upon to assist the client through a complex challenging rehabilitation process. In order to be facilitative in this role it is imperative for the nurse to be cognizant of the psychosocial components of the cancer experience, and to come to grips with his/her own feelings about cancer.

For many years, there has been a growing interest in the possibility that certain psychological factors are associated with the development of cancer. Personality theories suggest that persons who use an excessive amount of denial and repression seem more prone to develop cancer. Depression is thought by some to be a factor in increased susceptibility to cancer. Adler's organ inferiority theory postulates that each individual inherits an organ believed to be inferior to the others. Adler proposed that psychological factors involving the symbolic meaning of the organ to the individual may become instrumental in the onset of cancer in that organ.¹ It has also been suggested that persons may inherit a psychological factor which predisposes to the development of cancer.²

On the whole, studies like these conducted on psychological aspects of cancer development have not been well received by the medical profession. Although psychological factors may be associated with the persistent use of known carcinogens such as tobacco, or the failure of some persons to pay attention to suspicious symptoms, there is no conclusive evidence that a causal relationship exists between psychological factors and the development of a malignancy.

Even though the cause of cancer is unknown and the extent to which the psyche affects its development is questionable, there is no doubt that psychosocial factors play a great part in an individual's ability to accept and cope with the disease and its implications. Throughout each phase of the cancer experience, the client is called upon to make major adjustments in the way he thinks about himself, his diagnosis, his treatment and his future. As a nurse, you can assist and support the client in this time of change.

Diagnostic phase

Cancer carries with it a social stigma, a stigma that depicts cancer as unclean, painful and dehumanizing. As a disease process, it has never acquired the respectability accorded high status diseases such as coronary artery disease which is often associated with aggressiveness and "the good life." Part of the reason for this may be that cancer occurs most often in those body areas not generally spoken of openly eg. colon, rectum, breast, prostate, uterus, kidney and bladder. Whatever the reason, the stigma of cancer is so great that it is often carried beyond the patient's death to be veiled in the obituary notice ... "died after a long illness..." Frequently this is followed by a poignant request which asks friends to send donations to the Cancer Society in lieu of flowers.

For many, a diagnosis of cancer is equated with chronic endless debility, loss of muscular power and a withering away of life.³ Nearly every newly diagnosed patient can recall someone who has died from the disease. Thoughts of pain, mutilation, odor, helplessness, offensiveness, suffering and death are immediate reactions to the diagnosis. These thoughts may be compounded by fears of job loss, abandonment, and financial crisis. The friends who have been cured or who are living full lives despite their illness are forgotten when an individual learns that *he*, not someone else, has cancer.

A diagnosis of cancer is a tremendous assault to both the client and family. Self blame and projection are thought to be the two major psychological obstacles to an acceptance of the diagnosis. In addition, a belief that cancer is inherited or contagious is deeply ingrained in some families and communities.⁴ For example, the rush to obtain physical examinations is a common phenomenon among family

CANCER Experience

members of a newly diagnosed cancer patient. Some patients express a fear that their children might inherit the disease. The reluctance of friends, neighbors and sometimes family members to come too close to the patient or to touch him may indicate a belief in the contagion theory. This reluctance may also contribute to the client's fear of abandonment.

Confronting a diagnosis of cancer is always difficult and each client will have his own method of coping. A variety of coping mechanisms are used to deal with the threat of cancer. One observer has noted that some clients may go through an acute grief reaction as a normal response to the news of cancer.⁵ Another normal, protective means of adapting to the diagnosis of cancer is denial. In fact some patients may continue to use it as an adaptive mechanism throughout their entire cancer experience. In one study by Levine and Zigler, cancer patients were found to employ more denial than heart disease patients. The denial mechanism used by cancer patients was related to a denial of aspirations and was intended as a protection from facing a reality filled with frustration and despair.⁶

In some instances, however, clients are unable to adapt to the diagnosis and resort to unorthodox medical treatment. Others totally refuse treatment. The laetrile phenomenon is one example of this. Some have dismissed the laetrile issue as a failure on the part of the physician to point out the unpredictable nature of cancer and the possibility of unexplained remissions and cures. Although this point is well taken, the use of laetrile is also a complex psychosocial issue which underscores client vulnerability and the pervasive fear of cancer and its treatment on the part of a large portion of the population. The lengths to which a client or family will go to avoid legitimate cancer treatment should not be underestimated. The client and family's need for hope and their denial of reality is further emphasized in the use of laetrile when all other forms of medical treatment have failed.

How much should a cancer patient be told about his diagnosis? The question is a controversial one. Some maintain that most clients adjust best to the truth and factual information about the disease. According to this view, uncertainty raises questions and increases the client's anxiety. McIntosh interviewed seventy-four hospitalized patients with diagnosed but undisclosed malignancy to ascertain their awareness of their condition and desire for more information about it. He found that

although 88% of the patients knew or suspected they had a malignant tumor when they were admitted to the hospital, the majority of them had no wish to augment that knowledge. This finding suggests that many people might not want to know the diagnosis, preferring the anxiety of uncertainty to direct information.⁷

When the psychosocial factors are considered, there is little doubt that hope remains the most crucial element in the client's response to a diagnosis of cancer. Every cancer diagnosis must be explained to the person in a way that allows him to maintain a sense of hope. Although the diagnosis may be clear cut, the nature of cancer remains unpredictable. This fact should be used as the basis for hope and not despair.

Treatment phase

During the treatment phase, one of the most important factors to consider is the meaning that the illness and its treatment has for the client and his family. At this stage, they will have their own ideas about the relative merits of the different types of treatment. For example, clients and their families generally equate surgery with a cure. Radiation therapy may also be equated with a cure or control, but in the case of solid tumors, the client and family may feel that this indicates the cancer could not be cured by surgery alone. This makes the prognosis seem less favorable to them. Chemotherapy is most often associated with palliation and at best a guarded prognosis. Often the rapidity with which the client is moved from the diagnostic phase to the treatment phase makes it difficult for him to accept the proposed treatment in a positive way. On top of this, the client with cancer often feels very vulnerable — psychologically, socially and physically at this stage of his illness.

Each form of cancer treatment carries with it many fearful aspects. Cancer surgery is often extensive and radical involving wide excision of the malignant tumor and adjacent lymph nodes. Functioning body parts may be sacrificed in the process of removing a malignant growth. For the person with cancer, this can mean mutilation, disfigurement, sexual dysfunction, disability — changes that constitute an assault on his previous intact body image. An alteration in lifestyle and general quality of life will also be areas of adjustment he will have to face. The impact of all these changes can be devastating at a time when he is most

vulnerable.

Although surgery is often associated with a "cure", clients can be plagued with fears of recurrence, and feelings of unacceptability and isolation, all of which are sources of depression. Carrier has identified seven other reaction patterns which are common after cancer surgery and the other forms of cancer therapy.⁸ The reactions are: dependency, anxiety, anger and hostility, guilt, hypochondriasis, obsessive-compulsive behavior and paranoid feelings.

Most clients fear radiation therapy. They often lack an understanding of how radiation works and nearly everyone has heard of the nausea, vomiting, weakness and malaise that are part of radiation sickness. In addition, it is frightening for a client to be placed alone in a room with large machinery. When intracavitary radiation such as a radium implant is used, the client is subjected to isolation and the disquieting experience of having radioactive materials within the body. Though disfigurement and mutilation are not usually attributed to radiation therapy, the client must deal with many unpleasant side effects and after effects such as organ dysfunction, sterility and radiation burns. These aspects of radiation treatment can cause vast body image disturbances for the patient resulting in a loss of self-esteem.

Cancer chemotherapy involves a variety of different types and combinations of drugs. Because chemotherapeutic agents have an effect on both malignant and normal cells, a number of distressing side effects and body image disturbances are common. Hair loss, and masculinizing and feminizing effects, including sexual dysfunction, are associated with many cancer drugs. Toxic reactions such as severe nausea and vomiting can make the client look and feel very ill during the course of chemotherapy, a treatment which may in all probability only offer him palliation. Often because of bone marrow depression, the client must be placed in isolation which can further enhance feelings of unacceptability, loneliness and depression.

For the client and family, the treatment phase of the cancer experience is costly in both physical and psychological terms. When the outcome is successful, adaptation is facilitated by the feeling that "it was all worth it," in the end. This feeling generally exists even though the threat of recurrence, or a new primary cancer site is always present.

If the cancer continues to progress in spite of all efforts to halt its growth, the process of adaptation becomes increasingly difficult for everyone involved. The progression of the cancer may be dramatic with a rapid downhill course or it may progress slowly. Thus the terminal stage of the illness may be very brief or quite lengthy. The stages through which the client passes in the process of dying have been outlined by Kubler-Ross and others.

Anxiety and fear are common feelings of both the client and family during this stage. The client's greatest fear is almost always the fear of abandonment, though frequently this is not expressed. This is accompanied by fears of pain, suffering, loss of control of body functions and dependency on others. For most clients, however, anxiety regarding the pain of separation from significant others is greater than the fear of physical pain.

The manner in which a person passes through the stages of dying or vacillates from one to another is based on a lifetime of coping mechanisms and patterns of adaptation. The passage is never easy; it is simply less arduous for some clients than for others.

Nursing implications

The person learning to live with cancer will need the help and support of all those who care for him. Therapeutic assistance will be enhanced if open communication exists among all members of the health care team. Every effort must be made to avoid situations in which rehabilitative interventions are carried out in isolation. Inconsistency and lack of continuity in care are major obstacles to the rehabilitation of the client with cancer. Every cancer patient is entitled to a unified empathic approach on the part of the rehabilitators, based on a thorough understanding of his or her unique situation.

Communication

One of the foremost rights of the patient is the right to communication and that means more than the exchange of information. It means having the opportunity to express feelings about what is happening and to know that a caring person is listening.

Abrams has outlined patterns of communication which she believes exist in the cancer patient.⁹ These are:
1. *Initial stage*: In this stage, the patient anticipates a cure or an arrest of the disease. The client often displays optimism and freedom in communication

and uses a minimum of defense mechanisms. The client wants the truth, but Abram makes the point that the client should not be told more than he wants to know.

2. *Interval between initial and advancing stage*: (Follow-up period) A distinct change appears in the client's need to communicate. He begins to retreat from any discussion of his diagnosis.

3. *Advancing stage*: At this time, everyone is anxious and unnerved; communication reaches an impasse. Defence maneuvers on the part of the client and doctor are evident. The patient seldom confronts the doctor for information. The nagging fear of abandonment is handled by compliance to instructions and/or hospital regulations.

4. *Terminal stage*: Silence becomes the common language especially in the area of the patient's anxieties. Emotional problems involving abandonment and the ordeal of dying are of great magnitude.

Although this communication pattern does not apply to all cancer patients, it can provide the nurse with a useful framework. Awareness of the communication dynamics in each phase of the illness can be a guide in formulating a plan of care to meet client and family needs. In particular, it is important for the nurse to recognize the client and family's need to engage in anticipatory grief work in order to avoid the communications impasse described in the advancing stage.

Suicide and cancer

A philosophy of honest communication that allows for hope is instrumental in helping the client and family cope with the psychosocial problems of cancer. Weisman reports that failure to deal with the psychosocial issues may seriously reduce the survival time of the client and the value of cancer treatment. He found that suicide is an aberrant coping strategy used by a small but statistically significant number of cancer patients.¹⁰

Health professionals must learn to recognize the vulnerability of the cancer patient and then help him employ effective coping mechanisms. Those who are most vulnerable to feelings of suicide use strategies of avoidance and repudiation. They withdraw into a painful isolation characterized by fear of destruction from some external source. Weisman's work with cancer patients reinforces the need for a trusting, honest empathic relationship between health

professional and client. To be most effective, the relationship must be developed early in the illness, preferably at the time of diagnosis, and sustained throughout the course of treatment and rehabilitation.

The family conference

The family's need for support during the cancer experience is great. The family conference has been recommended as an effective means of dealing with the difficult issues facing the family of a cancer patient. The timing of conferences should be related to the course of the patient's illness.¹¹ For example, the first conference could review the circumstances leading to the client's referral for medical treatment, and current client needs. Family strengths and resources should be assessed. Decisions regarding treatment and client/family treatment related needs could be the topic of the second conference. The third conference might center on the need for home care, nursing home care or other alternatives to provide support for the client and family.

Through family conferences, the nurse is able to formulate reasonable expectations of the family and with this knowledge can facilitate the process of adaptation for both the client and his family.

Cancer client groups

Another intervention for meeting the psychosocial needs of cancer clients is a weekly group meeting. Group sessions provide a means of giving support to patients during the difficult transition of adjusting to a life-threatening illness. Through the groups, patients are encouraged to express their feelings of fear, isolation, depression and anger. Patients are able to gain understanding and acceptance of these feelings from other group members.¹²

A Terminal Cancer Psychosocial Unit

In 1976 Krant reported on the development of a psychosocial terminal cancer unit program. It was designed to ameliorate disturbances in family psychosocial systems, and to promote healthy adaptations when client death is a certainty. Krant described client/family intervention principles for the a) *Pre-death period*, b) *Death and one week post-death* and c) *Post-death period*. For the pre-death period he suggested the following interventions: establishing a relationship and opening

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blocked channels of communication; facilitating the mourning process and saying goodbye; catalyzing interactions with psychosocial support systems; fostering individuation and role rehearsal. Interventions during the immediate death period primarily involve assisting the family through the funeral experience. The post-death period intervention principles include: maintaining the relationship and facilitating the mourning process; understanding loneliness; reinforcing individuation; and exploring major decisions.¹³

Work is still being done to evaluate the effectiveness of these interventions. Krant and his colleagues are confident that the final evaluation will demonstrate that psychosocial units utilizing the interventions they have developed will be of tremendous assistance in helping patients and families to face the problems of terminal illness.

Summary

The nurse who is cognizant of the psychosocial meaning of cancer for the client and family is in a better position to assist them in the process of adaptation through the various stages of the illness. An empathic approach capable of sustaining realistic hope in each phase of the illness is crucial to the success of the rehabilitation effort.

Pamela Gaherin Watson (R.N., Massachusetts General Hospital School of Nursing; B.S. Nursing, M.S. Nursing, Boston University) is an assistant professor at Boston University's School of Nursing Baccalaureate Program. She is also the Chairperson of that school's Rehabilitation Nursing Master's Degree Program. She has had staff nurse experience and has taken part in many workshops and nursing committees. She has published articles in various nursing journals and is a member of the editorial board for Cancer Nursing. Currently, Pamela is a doctoral student in Rehabilitation Counseling at Boston University.

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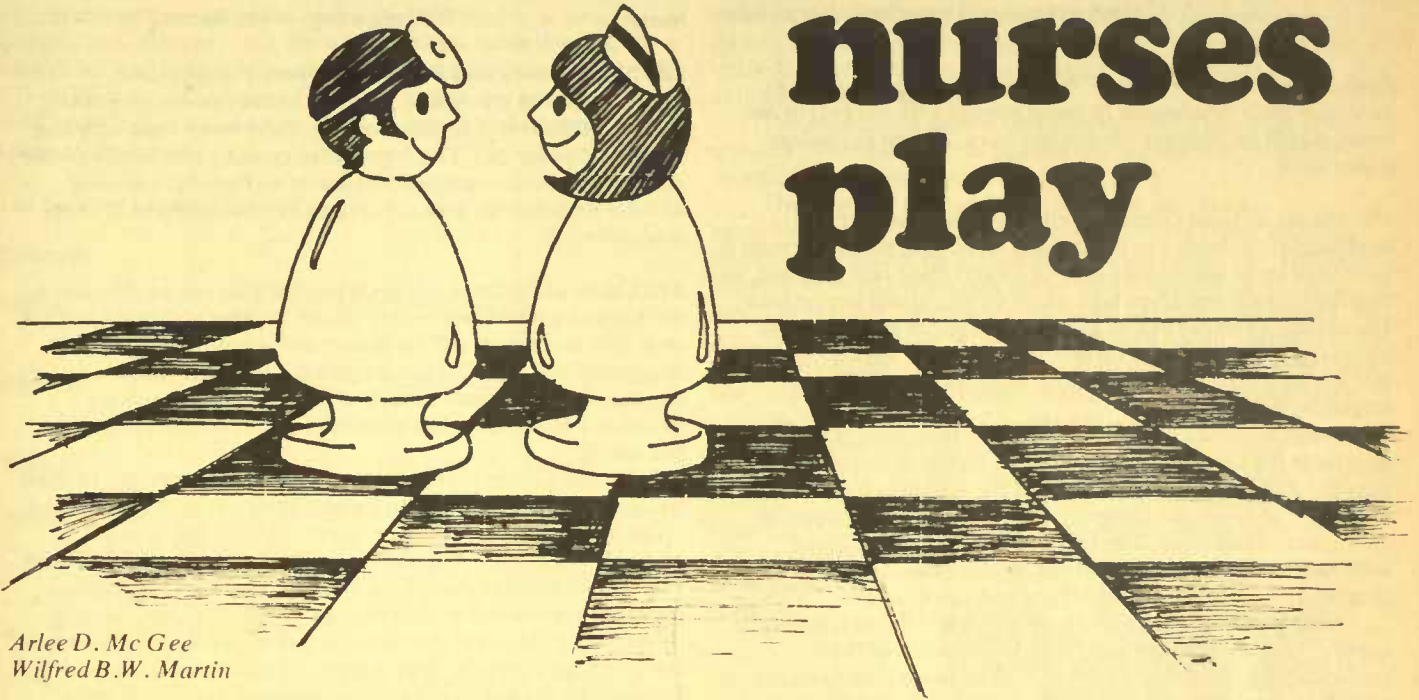
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The games nurses play



Arlee D. McGee
Wilfred B.W. Martin

Most nurses have heard of the "doctor-nurse game." Whether or not they are familiar with the term, they are familiar with the game and how it works. Closer examination reveals that interactions characteristic of the doctor-nurse game can also be identified between nurses and other nurses. It can be seen that games have a significant influence within the health care system.

A number of authors have looked at the reasons for game playing among health professionals. For example, it has been pointed out that the attitudes that one player has toward another will determine the games they play.¹ Others imply that because nursing and medicine use different languages, positive interactions between members of the two groups are stilted; the languages themselves become barriers to open communication.² It has also been suggested that by setting aside the old rules of the game, and by recognizing and accepting new rules, the game players will become equals in partnership.³

Whatever the reason, games in the health care system are a reality. To understand what they mean, it is necessary to isolate the specific games we engage in and to point out the consequences, for health professionals and for patients. Let's take a closer look then at some of the games nurses play.

The arena for game playing can be found in the community, hospital or any other setting where doctors and nurses attempt to communicate. The health care system itself becomes the game board where gaming strategies evolve. Many players may participate in gaming, but it is the doctor and nurse who set the stage for a third player — the patient.

Since the patient is directly affected by the strategies of the other two, it is necessary to analyze what happens in doctor-nurse interactions before trying to understand the consequences of those interactions for the patient, his immediate family and close friends.

The Games

While many games may evolve as players acquire new strategies, we have identified four major games that physicians and nurses play in their day-to-day work. These games can be labelled: *The Means as Ends Game*, *The Game of Pretense*, *The Game of Closed Negotiations* and *Monopoly*.

Means as Ends Game Example 1

Setting:	A post-partum unit in a large general hospital. Two nurses are talking in the hall.
First Nurse:	"If Mrs. Brown could look after her baby in her room more often, she might be more confident about caring for him alone."
Second Nurse:	"But it's against the rules. We only take babies out at feeding time. There are schedules to follow. All the babies go out to the mothers at regular periods."
First Nurse:	"Okay, it was only a suggestion."

Example 2

Setting: A nurses' station on a busy medical floor of a large general hospital.

Dr. Smith: "Miss Jones, could you join us for rounds?"

Miss Jones (Head Nurse): "I'd love to doctor, but these charts are such a mess, and somebody has to tidy them up."

Both doctors and nurses on 1 West have tried for months to persuade their head nurse to make rounds with the rest of the team. But Miss Jones is always too busy, tied up in endless paper work.

The Means as Ends Game is well known to observers of bureaucratic behavior in our society. It occurs when a person is so wound up in small tasks that he forgets their real purpose, so that the tasks themselves take on an unwarranted importance. The classic example can be found in the paper-pushing, rule following individual who forgets that his work has other goals, that is, the goals for which the organization or group was originally designed.

Why do nurses feel the need to play this game? One reason may lie in the fact that bureaucratic behavior in nursing is growing to encompass all aspects of the nursing environment. It is difficult to resist the temptation to slip into the routines of bureaucratic behavior. The fact that the professional and administrative roles of the nurse are intertwined has also contributed to the spread of Means as Ends Games.

Such games produce and help maintain "institutionalized nurses," nurses who are rigid with the security of their well-established habits.⁴ Obviously their resistance to change is a hindrance to progressive health care service. But because Means as Ends Games not only give the nurse a sense of belonging but also keep her preoccupied in the play itself, many nurses are drawn into the games without their full awareness. Involvement in such games cannot help but have negative consequences for the nursing profession and ultimately for the patient as well.

The Game of Pretense**Example**

Setting: The nurse's station on a medical ward.

Doctor: "25 mg of Librium four times a day for Mr. Brown."

Nurse: "Librium?? But Mr. Brown is for discharge tomorrow. He sleeps really well and seems to be detoxified from alcohol."

Doctor: (Ignoring the Nurse) "I guess 60 should be adequate."

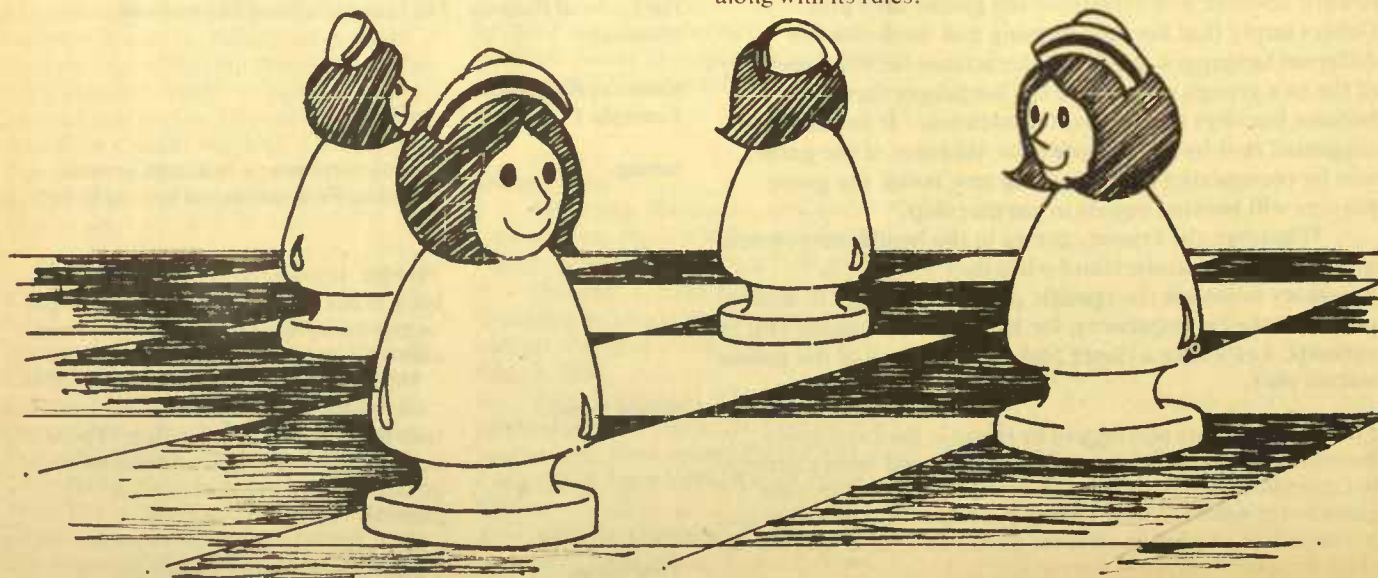
Nurse: "60 mg a day — yes doctor."

The Nurse knows that she has had more training and experience with alcoholics than the physician has had. She knows the patient's history and has spent more time with him than the Doctor has. The Nurse also realizes that studies have shown that minor tranquilizers are of no benefit in normal alcohol withdrawal, and she recognizes the dangers of cross addiction.

The Game of Pretense occurs when the players, in this case a doctor and a nurse, are aware of one another's identity but act as if they are not aware. In doctor-nurse relationships, it is suggested that both parties are conscious of the nurse's expertise. At the same time, both may assume that it is necessary to limit the boundaries of professional freedom for the nurse.

Doctors often pretend that nurses are subservient to them in a game that is designed to protect their overriding sphere of influence and autonomy. The nurse, like the nurse in the example cited, may respond by pretending to be satisfied with this type of partnership, often because she does not want to upset the traditional doctor-nurse role relationship. Such an upset may pose a real threat to the nurse, so she goes along with the game with a meek "yes doctor." The immediate cost of standing up for her rights as a professional may seem to be greater than the long-term rewards of professional development and autonomy for nursing.

Every relationship has its rights and privileges. The nurse's rights are due to her professional education and expertise and to the fact that she occupies a key position in health care. Once a sufficient number of nurses go after their rights vis à vis the doctor and in some cases, administrator, the rules of the game will be exposed for what they are worth. These nurses may initially be seen by some as risk-takers and role-breakers,⁵ but once the rules of this game are seriously questioned, it will be difficult for any nurse to continue to play it. The Game of Pretense will continue only as long as nurses are willing to go along with its rules.



It could be argued that the Game of Pretense does not exist between doctors and nurses, that the doctor is not pretending but merely unaware of the expertise and importance of the nurse. Such a lack of awareness is difficult to understand. It has been noted that "paradoxically enough, the medical profession, of all groups in health has not even for a moment underestimated the power of nursing."⁶

Similarly, it might be claimed that the nurse herself is not aware of the significance of her own expertise and importance in health care. But the extent of awareness on the part of the doctor or nurse is an empirical question. If there is a lack of awareness on the part of the nurse, it could be due to an unconscious ideology that the doctor knows more than the nurse about all things. If nurses are not aware of their potential, it is time for an awakening; if they are aware and not acting on their knowledge, it is time for them to question the rules of the Game of Pretense.

The Game of Closed Negotiations

Example

Setting: A telephone conversation.

Doctor: "Give Mr. Stephens 25 mg of Valium I.M. stat."

Nurse: "25 mg Valium I.M. Yes Doctor."

After this brief conversation, the nurse has second thoughts; 25 mg is hardly an average dose. Not only that, Mr. Stephens is a frail elderly man. So the nurse checks her drug manual and sure enough — the average dose for Valium is 5 to 10 mg. She decides to phone the doctor back.

Nurse: "Sorry, Doctor Jones, but I'm just checking to make sure of Mr. Stephens Valium order — did you say 25 mg I.M.?"

Doctor: (In a sharp snappy voice) "Haven't you given that yet? When I say stat, I mean stat." (click)

The nurse realizes that 25 mg is too much for Mr. Stephens. She wonders what to do about it. Obviously Dr. Jones is not open to suggestion.

The above example is typical of the Game of Closed Negotiations. Here one person, the doctor, has issued explicit

orders or directives and has refused to consider any input from the nurse. Obviously, such a game can lead to deterioration in interpersonal relationships, and sometimes to serious conflict between those concerned. In this case, there are negative implications for the patient as well. By refusing to accept input from the nurse, the doctor can exert control over her.

Although the consequences of questioning his "orders" are not explicitly stated, they are well understood by the nurse. If the nurse deviates from her accepted role (as seen from the doctor's perspective), both the doctor's directives and the consequences of 'disobedience' are brought to the fore. The boundaries of the nursing role as defined by Dr. Jones are clearly demarcated through closed negotiations. The nurse is left with little opportunity to be a part of the process of delineating her own role.

The suggestion here is that nurses should be a part of this process, attempting to change the interaction from a closed negotiation to a more open approach.

The Game of Closed Negotiations is also seen in nurse-nurse relationships, where one nurse is either appointed leader or is attempting to take over a leadership role. This may happen for example when a nurse who is appointed to a new position becomes dogmatic and closed to input from others. As a newcomer, she may be trying to define a social order for her new job even before she gets into it. In doing so, she may block out the perspectives of others even if they have considerable experience in the area. A casual observer can see many situations where nurses tend to block out each other's perspectives rather than opening negotiations about appropriate plans of action. A much more positive situation develops in the Game of Open Negotiations, where players make plans of action together.⁶

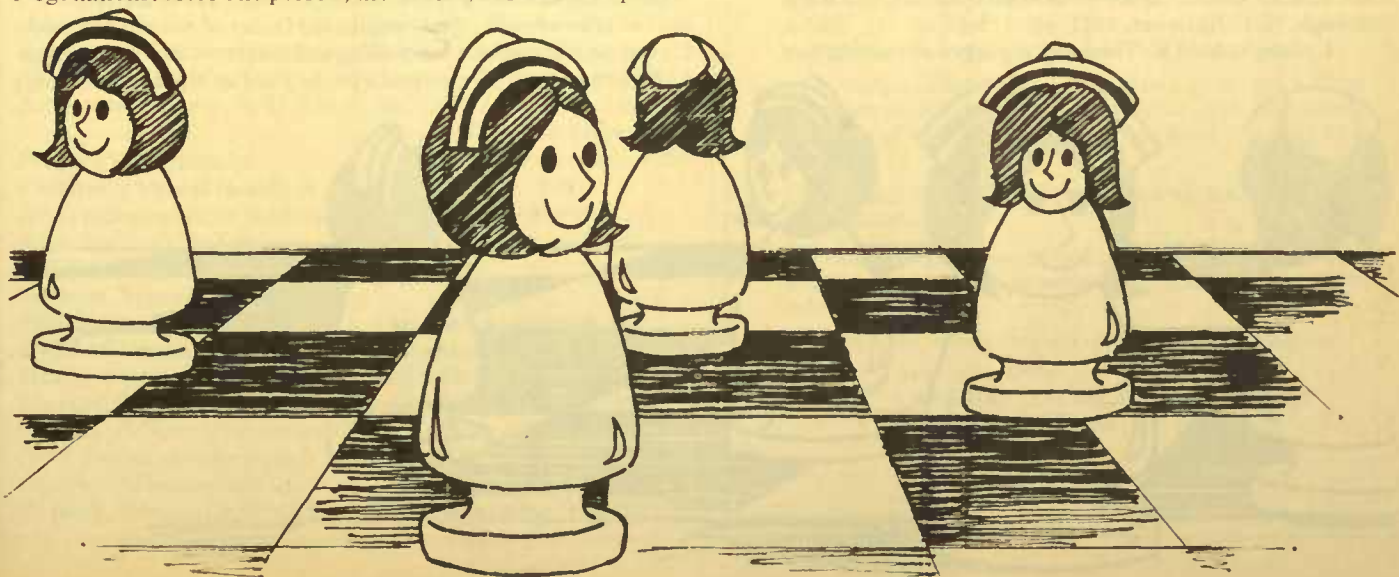
Monopoly **Scene:**

Nurse: Dr. Smith's office. Mr. Thomas, an elderly patient, has seen the doctor and is about to leave. "Did Mr. Thomas tell you about his leg, Dr. Smith. He was really limping when he came in. He ..."

Doctor: "You mentioned that to me already. See you next month Mr. Thomas. (to the nurse) Who's next?"

Nurse: "Excuse me doctor, but he had thrombophlebitis last fall — I have his old chart here. It's ..."

Doctor: (Ignoring the nurse and greeting his next patient) "Well, Mrs. Jones, how's Johnny these days ..."



As Mrs. Jones takes her son into the doctor's office, the Nurse thinks ... He's really pushing the patients through here. Mr. Thomas never complains, but he could get into real trouble with that leg. He was in the hospital for weeks last time. If only Dr. Smith would listen ...

Monopoly is a game that is clearly associated with the Games of Pretense and Closed Negotiations. It is only because one or more players can in fact monopolize a given situation that other games can be played. The rules for playing Monopoly in doctor-nurse interactions are interesting, because the players do not enter the game on equal grounds. But even though tradition has stacked the cards against the nurse, even though the nurse may recognize the need for change, the game is played from the traditional ground rules.

When nurses play Monopoly with other nurses, the results are similarly detrimental, because interpersonal relationships are affected in a negative way, and because the most desirable goals for the relationship are often thwarted. Although it is sometimes appropriate for leadership roles to exist in nursing, it is obviously important to have input from others in any decision-making process, implementation of plans and evaluation of outcomes. Many nurses have been stifled in their interactions with one another because of more or less domineering and authoritarian leaders. Because of the monopolistic approach of certain individuals the resources of other group members remain untapped, to the detriment of all.

The need for equitable rules should be obvious to everyone. Every doctor and nurse needs to have input into the process of health care with the status and prestige appropriate to their input. Fair play has its benefits for everyone, including the patient.

The games people play are an important part of the social organization of our society. Many of these games are what makes life worthwhile; they make significant contributions to all dimensions of our lives. Other games have more negative effects.

In nursing, the Games of Pretense, Means as Ends, Closed Negotiations and Monopoly can be seen as harmful, both to nursing and for patients. Unfortunately, our present health care system places importance on *Who* rules *Whom*, and this importance overrides the philosophy that the expertise of each player should have value in any interaction process.

Perhaps the key to change lies in awareness, awareness of one another's roles and goals. Awareness can open communication lines between players and facilitate the development of equitable rules.

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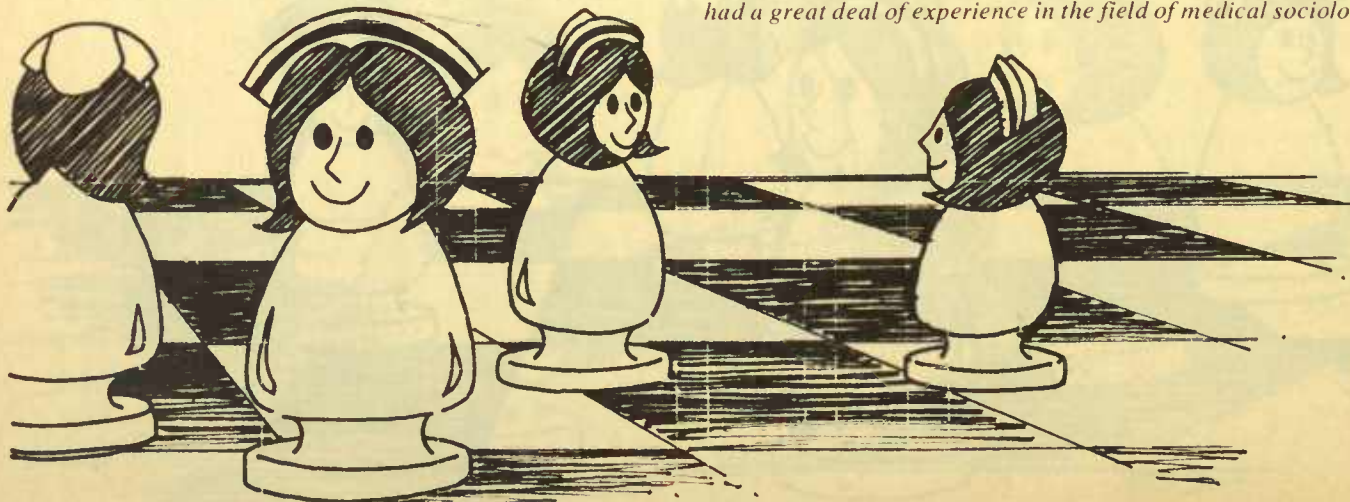
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Arlee D. McGee, R.N. (Victoria Public Hospital, Fredericton, N.B.) B.N. (University of New Brunswick) has had a wide range of experiences in nursing including general duty, public health and psychiatric nursing. She is now coordinator of an Alcohol and Drug Crisis Centre — Elm City Foundation — in Fredericton. Arlee was instrumental in starting a Home Visiting Teaching Programme for developmentally handicapped children in York County, New Brunswick. She also designed and taught a course for attendants working in Alcoholism Detoxification Centres, and completed a preliminary Research Project on "Alcoholics in the General Hospital" for the Dr. Everett Chalmers Hospital in Fredericton. As well as writing articles for *Reader's Digest*, the *Atlantic Advocate* and *NBARN's Info*, Arlee has written two articles for *The Canadian Nurse*, "The Nurse Continuum Perspective" in January 1977 and "Nursing the Alcoholic Patient" (June, 1977).

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Calendar

August

The Logic, Strategies and Tools for Student Clinical Evaluation. To be held on Aug. 17-18, 1978 at the University of Alberta Campus in Edmonton. Fee: \$45. Contact: *Faculty of Extension, The University of Alberta, Corbett Hall, Edmonton, Alta., T6G 2G4. (432-5070).*

Teaching Effectively in Nursing. A four-day conference for nursing instructors to be held in Calgary, Alta. on Aug. 21-24, 1978. Fee: \$125. Contact: *Faculty of Continuing Education, University of Calgary, 2920-24th Ave. N.W., Calgary, Alta., T2N 1N4.*

September

Annual National Workshop, Canadian Diabetic Association. Theme: Let's Be Practical About Diabetes. To be held on September 21-23, 1978 at the Valhalla Inn, Kitchener, Ontario. Fee: Members: \$75, Nonmembers: \$90. Contact: *Dawn Best, Publicity Chairman, Professional Health Workers Section, The Canadian Diabetic Association, c/o Kitchener-Waterloo Hospital, 835 King Street West, Kitchener, Ontario, N2G 1G3.*

Primary Prevention in Children's Mental Health. A fall symposium to be held on Sept. 21-22, 1978 at the Holiday Inn, Downtown Toronto. Sponsored by the Thistletown Regional Centre and the Canadian Mental Health Association. Guest speaker: Dr. Gerald Caplan. Contact: *Primary Prevention 1978, Thistletown Regional Centre, 51 Panorama Court, Rexdale, Ontario, M9V 4K8.*

'78 Epilepsy International Symposium to be held Sept. 10-14, 1978 in Vancouver, B.C. Contact: *CanWest Conference Services, 1315-925 West Georgia St., Vancouver, B.C. V6C 1R5.*

The Ontario Annual Assembly of Emergency Care to be held at the Skyline Hotel in Toronto on Sept. 11-13, 1978. Sponsored by the Emergency Nurses Assoc. of Ontario, the Assoc. of Casualty Care Personnel, and Ontario's Emergency Physicians. Contact: *M.G. Hutchison, Assistant Director of Nursing, The Mississauga Hospital, 100 Queensway West, Mississauga, Ontario, L5B 1B8.*

October

Ontario Occupational Health Nurses' Association Annual Conference to be held at the Valhalla Inn and Walper Hotel, Kitchener, Ontario on Oct. 25-27, 1978. Theme: A festival of learning. Contact: *Gloria J. Lippert, Publicity Committee, 900 Guelph St., Kitchener, Ont., N2G 4B5.*

Emergency Care Conference. "Field Care Priorities with Chest Pain and Head Injuries." Speaker: Dr. Ronald Stewart of Los Angeles. To be held on Oct. 20-21, 1978 in Willowdale, Ontario. Contact: *Seneca College, Leslie Campus, 1255 Sheppard Ave. East, Willowdale, Ontario, M2K 1E2.*

Canadian Association of Gerontology Seventh Scientific and Educational Meeting. To be held on Oct. 12-15, 1978 in Edmonton, Alta. Contact: *Donald R. Milne, Conference Chairman, 8515-144 Ave., Edmonton, Alta., T5E 2H5.*

Continuing Education Programs offered at the University of Toronto: *Recent Advances in the Care of the High Risk Pregnancy Patient and the Newborn Infant. Part 1 Sept. 19, 1978. Part 2, Sept. 26. Fee: \$25. Evaluations are for Growing. Sept. 20. Fee: \$25. Family Therapy Principles for Nurses. Oct. 3. Fee: \$25. Role Playing as a Teaching Method and a Therapeutic Technique. Oct. 5-6. Fee: \$60. How to be a Knowledgeable Consumer of Research. Oct. 19. Fee: \$15. The Problem of Skin Disorders for the Working Adult. Oct 23. Fee: \$50. Nursing in the Immediate Post Surgical Period. Oct. 25. Fee:*

\$25. Illustrate your Message. Oct. 31. Fee: \$25. Contact: Dorothy Miles, Director, Continuing Education Programme, Faculty of Nursing, University of Toronto, 50 St. George St., Toronto, Ontario, M5S 1A1. (978-8559).

Did you know ... The Class of '73 of Mount Royal College in Edmonton is organizing a five-year reunion. All members of the '73 class including all instructors are asked to send their name and address to: Heather (Mann) Horne, 2021 74 Street, Edmonton, Alberta., T6K 2L3.

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The president of the Registered Nurses Association of British Columbia, Sue Rothwell, answers questions from the delegates about the situation of nurses employed by the largest teaching and referral center in that province, the Vancouver General Hospital.



Close to 1200 delegates packed the Canadian Room of the Royal York Hotel for the opening ceremonies of the CNA convention on Sunday, June 25th.



The Lieutenant Governor of the Province of Ontario, Pauline McGibbon, (center) greeted CNA members who attended a reception at Queen's Park held in honor of the 70th anniversary of the Canadian Nurses Association. Among those in attendance were (left to right) CNA president-elect, Shirley Stinson; RNAO president, Irma Jean Bajnok; the Lieutenant Governor; former CNA president, Joan Gilchrist and the president for this biennium, Helen Taylor.

Organized nursing

The need for a national conference on nursing education, the accreditation of nursing education programs, health promotion, and examinations for R.N.'s wishing to practice in the United States were among the concerns of membership brought to the attention of delegates to this year's annual meeting of the Canadian Nurses Association. A total of six resolutions were presented by the chairman of the Resolutions Committee, Lorette Sutton, and approved by delegates (See below). Voting delegates also approved five motions brought to the floor of the convention during the concluding business session of the meeting. Chief among these was a unanimous vote of support for nurses at Vancouver General Hospital who have been fighting since last November against unsafe hospital conditions.

The situation was brought to the attention of the 1,200 delegates by representatives of the Registered Nurses Association of British Columbia. The delegation said it had reports of numerous documented cases of unsafe care at the VGH where nurses have been struggling to improve the setting for nursing care.

During discussion on the motion, it became clear that nurses attending the convention were concerned not only about patient care at the Vancouver hospital but also about similar conditions that may exist in other parts of Canada.

The motion approved by delegates was as follows: "That CNA take a stand to support nurses at the Vancouver General Hospital who have expressed concerns for patient care and who are seeking professional autonomy so that they can fulfill their professional responsibilities."

The other four motions passed were:

- That, as a matter of general policy, CNA take every opportunity to lend its support, in ways deemed appropriate by the CNA Board, to individual nurses and groups of nurses who are seeking to improve patient care settings, in order to be able to provide safe, competent nursing care.
- That the CNA membership take active measures to effect change in the physical and psychological environment of the maternal care system and provide alternate methods of delivering care within the structure of the present health care system.
- That CNA in accordance with the CNA Statement on the Nurse in Primary Care, 1977, urge universities with baccalaureate programs to assure the membership that preparation for primary care nursing is part of basic nursing education as soon as possible.
- That the CNA mobilize the necessary human and financial resources needed for the development and implementation, as soon as possible, of a doctoral program in nursing in Canada.

moves ahead with new goals and priorities

CONFERENCE ON EDUCATION

Whereas, Nursing education in Canada is taking a variety of directions resulting in an ad hoc proliferation of programs and "specialized" practitioners;

Whereas, There are continuing changes in student populations and demands of consumers in regard to nursing education programs;

Whereas, The trends in registration/ licensure, credentialing, development of standards of nursing education and nursing practice, the changing nature of specializations in nursing and moves toward accreditation all have implications for nursing education; and

Whereas, There has not been an opportunity for nurses from the provinces and territories to discuss issues and share problems as they arise on a national basis;

Resolved, That CNA take leadership in convening a national conference to enable nurses to address concerns related to the development of nursing education programs, diversity of "specialized" practitioners and current issues and problems accompanying these developments; and

Resolved, That a future conference be considered to include employers, consumers of nursing care, national, provincial and territorial nurses' associations and government planners.

U.S. STATE BOARD EXAMS

Whereas, French-speaking nurses constitute a large proportion of the membership of the Canadian Nurses Association; and

Whereas, Registered nurse examinations written in English by Canadian nurses are recognized by some U.S. State Boards as being of equal value as State Board examinations for admission to the professional practice of nursing in the United States; and

Whereas, French-speaking Canadian nurses who have passed registered nurse examinations in French in Canada must also pass the U.S. State Board professional examinations — which are, in effect, a test of their fluency in English — to be admitted to the professional practice of nursing in that State;

Resolved, That CNA study the rationale for the requirement by some U.S. State Boards on Canadian nurses who have written their registration examinations in French; and

Resolved, That CNA undertake all necessary steps to exert pressure on State Boards to have these licensing bodies recognize registered nurse examinations written in French by Canadian nurses as being of equal value to those examinations written in English; and

Resolved, That State Boards be urged to use a language proficiency test rather than professional examinations to evaluate fluency in English.

NATIONAL ACCREDITATION PROGRAM

Whereas, In September 1975, the Association of Universities and Colleges of Canada (A.U.C.C.) and the Association of Canadian Community Colleges (A.C.C.C.) formed a joint committee to study the practicability of establishing a permanent council to co-ordinate the accreditation of health sciences educational programs in Canada;

Whereas, The Canadian Association of University Schools of Nursing (C.A.U.S.N.) is developing an accreditation program for University Schools of Nursing;

Whereas, The A.C.C.C. is involved in the accreditation of health sciences educational programs other than nursing; and
Whereas, Canadian nursing education programs have no national accreditation process;

Resolved, That the Canadian Nurses Association develop in collaboration with the C.A.U.S.N., A.C.C.C., and other appropriate organizations a national accreditation program for nursing education programs.

HEALTH PROMOTION

Resolved, That the Canadian Nurses Association encourage association members to make known to the appropriate bodies and the public the view of the nursing profession regarding health and health related issues.

EDUCATIONAL PROGRAMMING

Whereas, National television programming is a valuable educational tool which reaches the majority of Canadian citizens;

Resolved, That the Canadian Nurses Association urge the Canadian Broadcasting Corporation to enrich its educational programming in the areas of health maintenance and promotion.

TAX EXEMPTION

Resolved, That the Canadian Nurses Association request the Department of Revenue to amend the provisions of the Income Tax Act in order that nurses and other salaried persons be granted tax exemption for monies spent in furthering their education in accordance with requirements for continuance in practice.



Following announcement of the election results, seven members of the newly elected CNA executive posed for this picture. Shown above, left to right, are: Ginette Rodger,

Odile Larose, Linda Gosselin, Helen Taylor, Myrtle Crawford, Sheila O'Neill, and Shirley Stinson.

Introducing your new executive

The 122,000-member CNA moves into the 1978-80 biennium with a new president and seven other newly elected officers at the helm. Voting delegates from the eleven provincial/territorial association members elected the following nurses to direct the affairs of the national association over the next two years:

President: Helen Taylor, director of nursing, Montreal General Hospital.

President elect: Shirley Stinson, professor, Faculty of Nursing and Division of Health Services Administration, University of Alberta.

First vice-president: Sheila O'Neill, nursing director, Medical Pavilion, Royal Victoria Hospital, Montreal.

Second vice-president: Myrtle Crawford, assistant dean, College of Nursing, University of Saskatchewan, Saskatoon.

Member-at-large, Nursing Administration: Ginette Rodger, director of nursing, Notre Dame Hospital, Montreal.

Member-at-large, Nursing Education: Margaret McCrady, director of educational services, Nursing, Health Sciences Centre, Winnipeg.

Member-at-large, Nursing Practice: Jessica Ryan, head nurse, Pediatrics, Chaleur General Hospital, Bathurst, N.B.

Member-at-large, Nursing Research: Odile Larose, director of nursing section, Order of Nurses of Quebec, Montreal.

Member-at-large, Social and Economic Welfare: Linda Gosselin, employment relations officer, Ontario Nurses' Association, Thunder Bay.

The new president of the CNA, Helen Taylor, is also chairman of the board of directors of the Canadian Council on Hospital Accreditation; a former president of the Canadian Nurses Foundation and former first and second vice-president of the Order of Nurses of Quebec.

A graduate of McGill University, where she received her B.N., M.Sc.(A) and Diploma in Teaching and Supervision, Taylor has served as president elect of the Canadian Nurses Association for the past two years.

Farewell address

Most facets of the health care system are currently undergoing change, some on an ad hoc basis, some carefully planned and uniquely formulated. The influence of the nursing profession in many of these innovations, however, is less than it might be, in the view of CNA's retiring president, **Joan Gilchrist**.

In her farewell address to delegates to the annual meeting at the close of her two-year term of office, the director of the school of nursing at McGill University suggested three areas where nurses might have a more positive effect on quality of care.

"In her work environment, the nurse is constantly striving to incorporate more efficient ways; she is assessing her own performance and that of her colleagues and modifying them in response. She is assisting in the planning, development and implementation of new forms of care predicated on increased patient involvement and cost effectiveness BUT she is not taking enough risks and initiatives in demonstrating new nursing roles."

In the area of professional and union environments, too, nurses need to work harder to demonstrate that the profession does not need to be separated into management and non-management or worker groups. Failing to do so, the speaker noted, promotes an untenable and dysfunctional divisiveness in the profession and in the work situation.

"In her community environment also," Gilchrist observed, "the nurse needs to be much more active than at present. She can provide a leadership role in the development of innovative community services. Her image will be enhanced through a public concern for her neighbors but the real reward lies in having fulfilled her responsibility as a citizen.



President's remarks

There likely has never been any other time in the history of nursing when the opportunities have been as vast in scope as they are at present, according to the new president of the CNA. **Helen Taylor** spoke to delegates at the close of the three-day convention. She urged the nurses in her audience and the nursing profession in general to make the most of these opportunities and realize that its responsibilities are real and very demanding.

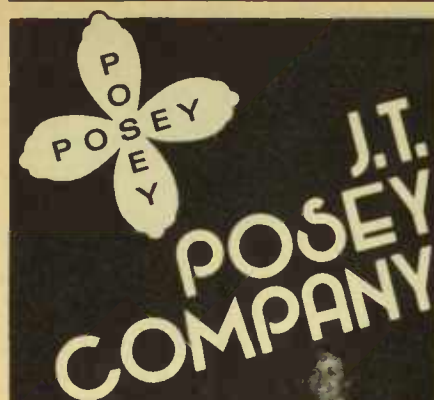
"These responsibilities must be born individually and collectively throughout the

profession. Major issues include the need for continuing to identify necessary changes for improved health care delivery, the definition of the scope of nursing practice, the delineation of needs for the education of nursing personnel, and the interrelationships between nurses and other health care systems."

Taylor said the nursing profession must press ahead with much determination and become increasingly visible and participatory in the planning and the developing of

new programs for health care. She said nurses must identify and approach the other professional groups with whom they can work in a constructive manner.

"We must be prepared to voice our beliefs and then to defend our principles especially when, due to economic or other modern day pressures, we are admonished by others to forsake those principles," said Taylor.



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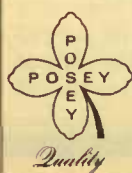
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Here's How

Orthopedic Ingenuity

On our orthopedic unit, we have a number of spinal surgery patients. One of our patients had had several major spinal operations in succession and was placed in a shell cast with both legs suspended in stirrup traction. Our problem was that this woman was almost completely immobilized, exhibited increased dependence on staff members and complete lack of motivation to help herself. Day and night, her bell was on for a glass of water or juice, a kleenex or some other small item. In order to increase her independence, we developed a few gadgets.

First, we filled a flip-top enema bag with ice water and suspended it from a low level IV pole. The tip of the tubing was cut off, and the clamp moved to a distance within three inches of the end. A 4 x 4 with an elastic served to protect the end of the tube from contamination between drinks. The patient soon learned to regulate the flow of water (or juice) and no longer required the constant attendance of a staff member. Her intake was also greatly increased because her fluid source was always at her fingertips.

Secondly, we taped several heavy clear plastic bags to the traction frame. These contained kleenex, vaseline, a comb, mirror, watch, pencils and other small personal articles. All were within easy reach of the patient.

The result of our efforts was that the patient soon developed an increasing sense of independence and became less demanding. She seemed more content, and her immobilization became easier to tolerate for the patient, her family and staff members.

— *Sheila Johnson, R.N., staff nurse, Orthopedic Unit, Ottawa Civic Hospital, Ottawa, Ontario.*

Emergency Peas

As a school nurse, how often have you searched the refrigerator for ice for an injury and found the ice cube tray empty — again? At our school, we keep a bag of frozen peas (if you prefer corn, it will do just as well) in the freezer for this type of emergency. We find it great because the bag molds around the injury and you

don't have to worry about melting ice. Not only that — it intrigues the younger children at the school.

— *Mrs. Jill Rhynard, Community Health Nurse, Vancouver, British Columbia.*

Up We Go!

If you have worked in a geriatric unit or a ward where patients are, to a large extent, bedridden, you probably know how difficult it is to move a patient from a "sliding-down position" to one that is more comfortable, up towards the head of the bed.

I have found the following helpful: Have another nurse or nursing assistant help you, from the opposite side of the bed. Position yourselves so that you are both facing the patient. Each place one arm under the patient's shoulders (the arm that is closest to the patient). Clasp hands under the patient, and lock your free hands around the bedpost.

If your patient is able to bend his knees, then he can be instructed to push up on your cue. If he is unable to push, this method will help you to pull him up with no discomfort to the patient and minimum strain to yourself.

— *Madelyn Crowther, staff nurse, Western Memorial Hospital, Corner Brook, Newfoundland.*

A Simple Vaporizer

A common question heard in well-baby clinics is that of what to do for an infant or child with a respiratory tract infection. Advice given usually includes the use of a vaporizer. However, the expense of buying this piece of equipment is often beyond the scope of many family's budgets. Furthermore, some vaporizers carry the potential hazard of causing burns when not used correctly.

In our clinics, we suggest an inexpensive and simple alternative. Parents are advised to hang a wet towel in the child's room near his crib each night. Because of the large surface area of the towel, we have found this to be much more effective than simply placing a pot of water on a radiator.

— *Nancy C. Edwards, Public Health Nurse, Baie Verte Peninsula Health Centre, Baie Verte, Nfld.*

Books

Textbook of pediatric nursing 5th ed. by Dorothy Marlow, ed. Toronto, W.B. Saunders Co., 1977. Approximate price \$18.30

Originally written for the nursing student of the early 1960's, this text is beginning to show its age. In this fifth edition, Marlow has made extensive additions and changes within the original format in an attempt to bring the text up to date. The result is certainly a more acceptable book than the former editions.

The inclusion of a chapter on the nursing process applied to the care of a child, with examples of how the authors have used the process in planning care, addresses a concept that was previously missing.

Current theories of child care, growth and development have also been included through additions to the earlier text. In this way, therapeutic play, preadmission preparation, emergency room care and concepts of development, sexuality and intellect are addressed.

Many pictures, graphs and charts have been added and they help to expand and enhance the text. There is even a table of mortality statistics for Canadian children. Complete revision of reference material has resulted in the inclusion of much current useful material. Unfortunately, in the process some valuable older references have been omitted.

The section most extensively expanded is that concerning the adolescent. Here new styles of health care delivery such as free clinics are discussed. The emphasis is placed on the adolescent becoming responsible for his own care — there are also allusions to the legal implications of this trend.

Sample nursing histories are included for each age group and some emphasis is placed in the newer parts of the text, on the nurses' problem-solving ability. Assessment skills are also more visible than in former editions.

The text still uses the disease oriented approach to nursing but the diseases discussed are generally those seen in the pediatric population of 1977.

The verb "should" has been conscientiously erased in the new edition, which makes the advice offered more acceptable than previously. However, white middle-class values still appear as the accepted norm throughout.

I feel that the 5th edition of "Pediatric Nursing" is an acceptable text for educators at the community college level. Information is accurate and easily available, which also makes this book useful for a quick reference in pediatric wards and departments. For those requiring in-depth information or thought provoking material, and for B.Sc.N. students, it would be inadequate.

Reviewed by Brigid Peer, M.S.N., assistant professor, Faculty of Nursing, The University of Western Ontario, London, Ontario.

Current practice in pediatric nursing. Volume 1, edited by Patricia Brandt, Peggy Chin, and Mary Ellen Smith. 241 pages. St. Louis, Mosby, 1976. Approximate price \$11.05 (paperback - \$7.90)

The stated purpose of this collection of contemporary articles is "to present to the reader personal experiences that illustrate therapeutic nursing strategies."

This is an interesting informative collection written exclusively by nurses — graduate students, teachers, clinicians — and covering a wide range of pediatric topics. Its orientation is toward the child and family in a variety of health settings.

Part I, "Roles, Theories and Tools" includes a discussion of the pediatric nurse practitioner's role as a collaborative member of the health team; a study of maternal behaviors significant to the development of early mother-infant attachment; and an adaptation of Otto's "actualization of human potential" method as a tool in relating effectively with a family of another culture.

Of particular interest was a discussion of a nursing role in a day-care setting and an excellent description of separation anxiety that the center prepared for parents. The author suggests that contrary to present belief, the infant's play is not solitary. Even though the young toddler seems to be included in the "infant" category here, it remains a stimulating question.

Part II, "Understanding Family Needs During Fetal Development and Early Childhood" explores the effects of maternal and infant nutrition on the child's brain growth and intellectual

development; maternal attachment in relation to failure to thrive; and a description of family planning methods. One article deals with supporting parents after the birth of a handicapped child and was meaningful in its emphasis on communicating with the mother while still in hospital postpartum and planning for the child's care at home.

Part III relates to the care of children with special problems. One author's guidelines for teaching the mentally retarded child to assume independence in the activities of daily living is based on behavior modification techniques, the child's readiness, and family involvement. Another author explores the coping behaviors of a preschooler hospitalized with burns. She presents a method to assess a child's coping strategies and utilize the results as a basis for nursing intervention.

Two articles creatively apply pain theory to the care of a preschooler and preadolescent. The remaining articles relate to preparing a child and family for cardiac catheterization and possible surgery, and the care of the family of a child with sickle cell disease.

Reviewed by Elizabeth Bray, nursing teacher, Ryerson Polytechnical Institute, Toronto, Ontario.

Suicide: Assessment and Intervention by Corinne Loing Hatton et al. 220 pages. New York, Appleton-Century-Crofts, 1977. Approximate price: \$9.75

This manual is primarily intended for practitioners, volunteers and learners in the area of suicide prevention. The authors are nurses and their book is based on their community clinical experience and their need for a single book that would combine theory and practice. As such, this book successfully achieves its goal and is useful to a multiplicity of care givers — nurses, social workers, clergy, police, psychologists and physicians. It is both exciting and encouraging to read a book written by nurses for nurses and other professionals rather than the all-too-common reverse with other professionals writing for nurses.

Few if any books about suicide have dealt with the problem in scope and quality as this book has. The authors,

along with eleven contributors, have identified the issues and emphasized practical application. The book goes beyond the usual discussion of historical and sociological perspectives and assessment to examine the survivor-victims of a suicide, variables in suicide statistics including ethnic aspects, suicide in children and adolescents, the chronically suicidal person, and what to do in an emergency. The chapters on intervention are strengthened by numerous case studies with excerpts from conversation to illustrate the principles of assessment and intervention. References at the end of each chapter provide an additional bibliography.

The book's usefulness to Canadian readers may be limited in the area of statistics and ethnic variables. The chapter is based on information gathered by the Los Angeles Suicide Prevention Center and deals with the Black and Mexican-American population. It would be interesting to see a future publication dealing with the seriousness of the suicide problem in Canada.

I would highly recommend this book as a source book on suicide; it is comprehensive, easily read, specific and practical.

Reviewed by Janice M. Bell, Assistant Professor, Faculty of Nursing, University of Calgary, Calgary, Alberta.

Normal development of body image and Distortions in body images in illness and disability (two volumes) edited by Fay L. Bower. Toronto, John Wiley and Sons, 1977. Approximate price for each volume \$5.95.

Designed to fit into any nursing curriculum pattern as well as staff development programs, the four contributing nurse authors of this concise two-volume module have effectively proven their two major points:

1. that a nursing model of body image is workable in all phases of the nursing process.
2. that learning this concept in an independent active method recognizes the need for flexibility and individualized learning.

Each volume, about 110 pages in length, follows the same format: pretest, learning objectives, directions, activities, progress checks and post test. Some of the modules contain reference to media tapes, films, slides, books or games. Although diagrams and illustrations are few, they are most effectively used (in particular the nursing model of body image, which symbolically represents three levels of body experience interacting with six environmental variables taking place

over a time span from fetal life to the elderly person).

The five modules in the first volume move from knowledge of the concept and its importance in nursing to all stages of human development. The nursing process' emphasis on assessment, promotion and detection of early deviations is aptly integrated. The use and illustrations of actual but simple psychometric tests are most helpful. Here the authors assume that learners have an adequate background in psychometric testing principles, so that teachers may find it necessary to augment their teaching with additional interpretation and guidance.

The second volume, "Distortions in body image in illness and disability" made up of another five modules, views each phase of the nursing process as fully as the first volume. Common conditions experienced by the ill and hospitalized individual related to man's developmental stages include: blindness, diabetes, deafness, neurological trauma, leukemia, surgical trauma, surgical removal of a body part, myocardial infarction and leukemia. The last chapter deals with distortions in body image due to personality disorganization evidenced by the individual who is neurotic or psychotic.

These volumes are soft covered and can easily be placed in a three-ring binder as intended by the authors. They represent one of the finest attempts in producing concept modules on a most significant human concept, only recently identified by health care workers. Invaluable to both teacher and learner, they accurately represent in condensed form, all current literature on this subject to date.

Reviewed by Claire Chuckla, Instructor, Psychosocial Nursing, Cariboo College, Kamloops, B.C.

Physical growth and development: from conception to maturity by Isabel Valadian and Douglas Porter, Boston, Little Brown and Company, 1977. Approximate price: \$12.00

This programmed text is suitable for any nursing student taking a course in growth and development. It deals strictly with the physical growth and development of an individual from conception to maturity.

The book is made up of 16 chapters. The first chapter discusses the assessment of physical growth. This is followed by a chapter on the principles of physical growth and development. The remaining 14 chapters are divided into body systems.

Each system follows an in-depth presentation using the following formats: introduction, anatomy and physiology,

and development through the various stages — prenatal, postnatal, childhood and adolescence.

At the end of the book, there are a series of tests that the student may use to test the knowledge gained from the use of the text.

Since this book is useful only as a study of physical development, it should only be used in conjunction with other texts on the psychosocial development of the individual. As such, it is a useful text for students.

Reviewed by Mary Card, B.N., teacher, Health Science Centre, School of Nursing, Health Sciences Centre, Winnipeg, Manitoba.

Library Update

Publications recently received in the Canadian Nurses Association Library are available on loan — with the exception of items marked **R** — to CNA members, schools of nursing, and other institutions. Items marked **R** include reference and archive material that does not go out on loan. Theses, also **R**, are on Reserve and go out on Interlibrary Loan only.

Requests for loans, maximum 3 at a time, should be made on a standard Interlibrary Loan form or by letter giving author, title and item number in this list.

If you wish to purchase a book, contact your local bookstore or the publisher.

Books and documents

1. *American Hospital Association Resource catalog*. 1978 edition. Publications and audio-visual products, Chicago, 1978. 75p. **R**.
2. *American Nurses' Association Facts about nursing 1976-77*. Kansas City, Missouri, 1977. 330p.
- 3.—. Perspectives on the code for nurses. Kansas City, Mo., c1978. 60p.
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6. *Baldonado, Ardelina A.* Cancer nursing: a holistic multidisciplinary approach, by...and Dulcelina Albano Stahl. Garden City, N.Y., Medical

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USE A SEPARATE SHEET OF PAPER IF NECESSARY

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45. *World Health Organization* World directory of schools for medical laboratory technicians and assistants, 1973. Geneva, 1977. 567p.

Pamphlets

46. *American Nurses' Association* Health care at home: an essential component of a national health policy. Kansas City, Mo., c1978. 18p.

47. *L'Association Canadienne d'Hygiène Publique* L'infirmière et la santé communautaire; fonctions et qualités requises pour l'exercice des soins infirmiers au Canada. Ottawa, 1977. 15p.

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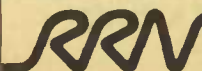
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Qualifications - Minimum

Graduation from University to the level of a Baccalaureate Degree with some hospital administrative experience; or any combination of relevant training and experience. Normally involved only with in-house educational services.

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Qualifications: University graduation with major course work in nursing plus five years of public health nursing experience, two years of which should be in a supervisory and administrative capacity or equivalent. A Master of Public Health or a Master's Degree in Nursing is required. Applicants should be registered or eligible for registration as a nurse in the Province of New Brunswick. Competence in English is essential; however, competence in both Official Languages is desirable. Candidates interested in a term position may be considered.

Location: Department of Health
Fredericton

Competition Number: NB 78-52

Apply in writing to:

New Brunswick Civil Service Commission
Room G-15, Centennial Building
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The Canadian Nurse

SEPTEMBER 1978

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Volume 74, number 8

SEP 26 1978

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Morning rush hour traffic was at its peak when Air Canada Flight 189 crashed on takeoff at Toronto International Airport, Monday June 27. Doctors and nurses from many Toronto hospitals arrived as soon as traffic allowed but Health and Welfare Canada nurses employed at the airport were on the site less than five minutes after the crash.

Photo courtesy Toronto Sun.

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses Association.

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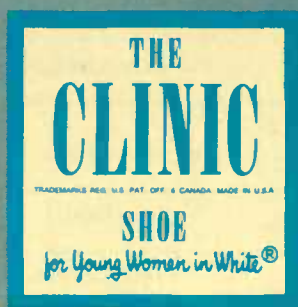
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perspective

One of the pleasures of public transport, for me anyway, lies in reading the variety of messages directed at this captive audience by way of the miniature billboards posted at eye level for the convenience of straphangers like myself. These consumer directives urge us to change our brand of panty hose, to try a new brand of beer or, sometimes, just to show a little consideration for our fellow passengers by moving along to the back of the bus.

A sign that was new to me caught my eye recently. "If you love life," it read, "make sure the love affair lasts." The message is from the Canadian Cancer Society and it goes on to point out that it's up to each one of us to do our part in keeping ourselves healthy — by avoiding over exposure to the summer sun, by having a Pap smear at recommended intervals and by refraining from smoking.

"It's up to you" is the way Cancer Society officials phrase their message and the phrase has the convincing ring of an old-fashioned home truth. It IS up to us. It's up to us, first of all as individuals, to take the steps we can to safeguard our own health.

We know, better than most people what those steps are. We know what happens to our waistline when we eat too much. We know we feel better, sleep better and look better when we exercise — whether it's a fast game of tennis, jogging or just a brisk walk around the block. We know too about the link between smoking and bronchitis, emphysema, cardiovascular disease and lung cancer.

As nurses it's also up to us to pass this message along to

our clients. Patient education has to be one of the most important, if least understood areas of nursing practice. Homes, hospitals, schools, factories and offices all provide us with the opportunity to share the knowledge that we have with the people we meet there.

We can impress upon them our own realization of the fact that the best medical care in the world, the most up-to-date hospitals and clinics and our own hard-earned nursing skills are wasted unless the people who make use of them accept their share of the responsibility for maintaining their own bodies in as healthy a state as possible.

The Cancer Society is right. It's up to you — and to me. To all of us. It's a question of health, and of life itself.
— M.A.H.

herein

*"What is happening to my people? Where have they gone? When my brother becomes ill, who helps him? If my child is sick, who do I turn to? Why must I wait for a plane to deliver me to the care of a physician? Why must I wonder where my child is and if ever I shall see him again? Why am I turned away from hospitals because of provincial jurisdictions? Who is that stranger coming to tell me what is good for me?"**

How does it feel to be on the receiving end of the health care that this country makes available to its native citizens? For that matter, what's it like to practice nursing in an isolated nursing station in Canada's far North or on an Indian reserve in Ontario or an out-patient clinic in Manitoba?



More than a year ago, members of the editorial staff of this journal decided to try to find the answers to some of these questions. We talked about the responsibility that a professional journal has to provide its readers with information that increases their awareness of contemporary social problems. Then we decided that we would try to communicate, in the words of both native and non-native people — the people who administer care and those who receive it, — a non-judgmental report on the realities of these needs in relation to traditional Inuit and Indian cultures and values.

It was to be an adventure in "cultural consciousness raising" and as such was something new and exciting for those of us who got caught up in the project. Next month, readers of *The Canadian Nurse* and *L'infirmière canadienne* will get a chance to see the results. We hope that you find the ideas and information in the October issue thought-provoking as well as informative.

We've tried to provide a representative sampling of opinions and ideas from a variety of concerned people. Our contributors include Indian nurses, doctors and nurses working in the field, native health workers and a couple of clients.

We don't pretend to have come up with any definitive solutions. We are simply asking you, the nurses of Canada, to look at some of the problems and to give some thought as to what the nursing profession is going to do about finding answers once the questions have been asked.

Or are we going to go on being "strangers?"

*The first Assembly of Registered Nurses of Indian Ancestry, Montreal, Quebec, August, 1975.

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Input

The Canadian Nurse invites your letters. All correspondence is subject to editing and must be signed, although the author's name may be withheld on request.

Fight against torture

I would appreciate the opportunity of informing my nursing colleagues of the recent formation of the medical group of the Canadian section of Amnesty International. In so doing, Canada became the eighth such country joining Denmark, Holland, Switzerland, Sweden, France, Greece, and the U.S.A. in combatting the practice of torture.

The Canadian group welcomes the involvement of any health care professionals. We anticipate that nurses could assist in the following:

- support of health professionals imprisoned for refusal to participate in torture and for treating torture victims and others in their own country,
- sponsorship of resolutions condemning torture,
- co-ordinated action with the international nursing community against authorities of countries in which there is systematic torture, and
- assisting in the care and on-going rehabilitation of refugee torture victims.

As members of a profession dedicated to caring for others we have much to contribute to the fight against torture. Interested nurses may obtain more information by writing:

Amnesty International
Canada, C.P. 6033,
2101 Algonquin Ave.,
Ottawa, Ontario,
K2A 1T1.
or by writing directly to the
chairman of the medical
group:
Dr. Charles F. Merrill,
20 Kimbermount Drive,
St. Catharines, Ontario,
L2N 5V6.
—Eleanor Nielsen, Reg. N.,
London, Ontario.

Pros and cons

I am writing regarding breast-feeding and to ask "What about the effects of breast-feeding on the mother?"

A mother who has had a complicated pregnancy, long hard labor or hemorrhaged needs all her strength to cope with a newborn 24 hours a day without being further drained by breast-feeding.

Also, what happens to the mother who is up most of the night with the baby and all day with her other children? She is still expected to be the perfect little mother breast-feeding her baby and maintaining a spotless home besides.

I think it's time we heard the pros and cons of breast-feeding for *both* mother and baby, instead of making the mothers who cannot breast-feed feel guilty.

—Gail Shultz, Kitchener, Ontario.

Comment

I read with interest "Perspective" in the May issue of *The Canadian Nurse*. I certainly sympathize with your predicament in expenses. You're quite right about your "reclassification into much more expensive and less efficient third class category" in regard to postage. The May issue of *The Canadian Nurse* is the first issue of the magazine that I have actually received the same month it was published.

In reference to Zak Sabry's editorial in February I feel that we don't encourage breast-feeding long enough. The majority of mothers in my area do breast-feed their babies but not for a long enough time such as nine months. They usually only breast-feed three months.

Another area I feel isn't stressed enough is proper nutrition for women all through life — women in both urban and rural areas. One would think that the rural life would promote healthier pregnancies and better attitudes towards health promotion but this has not been my experience. The whole area of nutrition should be stressed by community health nurses and hospital nurses in their contact with patients.

I just want to say that your May issue of *The Canadian Nurse* will be considered one of your very best issues of 1978, as I read, enjoyed and absorbed every article. Hoping your good efforts will continue.

—Judy Zakulis, Reg. N.,
Central Peace General
Hospital, Spirit River, Alta.

International spirit

Thank you very much for the honorarium and complimentary copies of the May 1978 issue.

I was so delighted with the cover picture and photos that accompanied my article! It was a very appropriate month for this article to appear since we are now in the midst of the International Congress of the World Federation of Public Health Association here in Halifax.

The Canadian Nurse has made an excellent contribution toward friendship and the spirit of internationalism, most especially at a time when the peasant paintings are touring Canada.

Thank you so much for such delightful coverage, appropriate timing and friendly co-operation.
—Barbara A. Devine, School of Nursing, Dalhousie University, Halifax, N.S.

Counting heads

In relation to the Kellogg National Seminar on Doctoral Preparation for Canadian Nurses, to be held in Ottawa, Nov. 1-3, 1978, we are preparing an inventory of all nurses in Canada with earned doctorates, and all Canadian nurses currently enrolled in doctoral programs (full-time or part-time) in Canada and elsewhere.

To obtain names, we are contacting the CNA, CNF, all provincial nursing associations and all Canadian university schools of nursing.

We would ask readers of *The Canadian Nurse* to notify us of the names and addresses of any nurses who we are unlikely to identify through the above means, especially nurses currently enrolled in doctoral programs in or outside Canada.

Many thanks for your help.

—Shirley M. Stinson, R.N.,
Ed.D., (Project Director)
Faculty of Nursing, 3-104
Clinical Sciences Bldg.,
University of Alberta,
Edmonton, Alberta, T6G 2G3.

Nurses on strike

Federal nurses across Canada are now into the second week of strike action. Our negotiations for elimination of the 20 percent wage disparity with our provincial counterparts, and recognition for our outpost nurses, who function as general practitioners have, to date, been futile. Treasury Board has not even made a reasonable offer!

The present situation in the Sioux Lookout Zone is particularly appalling. Circumstances have forced the reduction of services at the Sioux Lookout Zone Hospital to emergency and acute care only. All but four patients have now been

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REALITIES IN CHILDBEARING

By Mary Lou Moore, RN, MA. Based on the belief that childbearing is a social as well as a biological event, this new text presents maternity nursing in a socio-cultural context, accurately reflecting today's realities in pregnancy and family life. You'll find detailed coverage of normal labor and delivery and care of the high-risk mother and infant. Fascinating discussions of current issues examine consumer desires vs. traditional nursing practices; single parent families; unplanned, adolescent and problem pregnancies; cultural differences in childbearing among Black, Spanish-American, Asian, and other families; and effects of the Women's Movement on nursing care and childbearing. 772 pp. 228 ill. May 1978. \$17.25.

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By Martha Underwood Bamard, RN, MN; Barbara J. Clancy, RN, MSN; Kermit E. Krantz, MD; with 28 contributors. You will gain a multidisciplinary insight into human sexuality from this text. Stressing the psycho-social and cultural aspects of sexuality, the book discusses normal sexual function as well as sexual problems and how to alleviate them. It covers the full range of topics with which health professionals must be familiar to provide comprehensive health care. Topics range from specifics such as birth control methods, rape trauma, and infertility, to general areas such as counseling, sex education, and adolescent problems. 301 pp. Illustd. Soft cover. \$11.45. April 1978 Order #1544-9.

NURSING IN SOCIETY: A Historical Perspective, New 14th Edition

By Josephine A. Dolan, MS, RN, PhD. This classic text examines the historical development of nursing from Biblical times right up to the present. This new edition features expanded coverage of the past several decades in nursing; recent developments in nursing education and practice, such as the controversial 1985 proposal; and a new chapter on Florence Nightingale which provides insight into the emergence of modern nursing. Many new illustrations have been added. An Instructor's Guide will be available. About 405 pp., 290 ill. About \$21.85. Just Ready. Order #3133-9.

CLINICAL WORKBOOK IN MEDICAL-SURGICAL NURSING

By Rosemary Bouchard Kurtz, RN, EdD; and Nancy Frost Miller, RN, MS. This excellent workbook presents clinical nursing case studies of patients suffering from a wide range of acute and chronic disorders. Special emphasis is on how individualized nursing care relates both to the patient and to his family. Patient education and rehabilitation are indicated, thus serving as a basis for further assessment, intervention and evaluation. The units include care of the patient with: burns, diabetes mellitus, renal failure, Parkinson's disease, and fifteen other disorders. 191 pp. Illustd. Soft cover. \$8.65. May 1978. Order #5580-7.

Input

► transferred to other institutions. Despite the reduction of patients, the administrative and support staff are still necessary and must function in their usual capacity. One must recognize and acknowledge this situation as demonstrative of a tremendous waste of hospital space, personnel and government funds.

The situation in the isolated outposts is even more deplorable. There is but one designated nurse in each of the seven nursing stations. These nurses have been "on call" 24 hours a day since commencement of strike action twelve days ago. They are understandably exhausted, and as a result of human limitations are forced to administer necessary health care on a severely diminished basis.

The health care of Canadians is obviously being compromised. In light of this fact, Treasury Board's failure to take immediate action, demonstrates undisputed neglect. Furthermore, Treasury Board has breached the promise made at the last contract negotiations, to grant provincial parity. I contend that further delay by Treasury Board to enact its responsibilities is intolerable.
—Joan Murchison, Reg.N., B.Sc.N., Federal Nurse, Sioux Lookout Zone.

Protecting the little ones

This is an appeal to pediatric nurses across Canada to re-evaluate their beliefs about parental involvement and children's rights on pediatric wards.

Twice in the past month I have been told about toddlers being pinned screaming to their cribs for I.V. therapy.

Their parents were told to stay home for a couple of days because they were upsetting the child and he might pull out the I.V.! They were encouraged to return when the child was better.

Can it be true that these nurses are unaware of the emotional and psychological damage that this will cause the child?

These incidents happened in two different provinces and I'm sure they are daily occurrences all across Canada. It's time that each pediatric nurse examined his/her beliefs, attitudes, and work situation to determine whether or not they are helping to make each child's hospital experience a positive one. Too often, the only consideration is for the child's physical well-being. Little or no thought is given to his emotional well-being.

It is easy to say "we already have 24-hour-visiting hours for parents, so we're doing a good job," but both these incidents occurred in that situation. If parents are merely tolerated or can be asked to leave at any time by the nurse in charge of each shift, then the situation isn't good enough! Parental involvement must become a major part of ward policy and attitudes of administration and medical staff must change as well. But first, a change must occur in the nursing staff.

It is every child's right to have his parents with him during hospitalization, and it is our responsibility as pediatric nurses to safeguard this right.

—Judith Pakozdy, R.N., Edmonton, Alta.

Memorial Fund

Plans have been made to set up a memorial to Jessie McCarthy who died in 1977, in recognition of her contribution to nursing education and service.



A group of nurses has formed a committee to explore the possibility of the fund. Because of McCarthy's interest in continuing education for nurses, it has been suggested that the fund be used to help registered nurses in their studies.

Donations and suggestions may be sent to: Grace Adamson, Treasurer, Jessie McCarthy Memorial Committee, 3940 West 12th Avenue, Vancouver, B.C., V6R 2P2.
—Jean Little, Member, Memorial Committee, Vancouver, B.C.

Editor's Note: *Jessie McCarthy, the first woman to be elected to the national management committee of the Canadian Tuberculosis and Respiratory Disease Association, was a nurse epidemiologist and an assistant professor in the Department of Health Care and Epidemiology, Faculty of Medicine, University of British Columbia. Her wide nursing experience included both general duty and public health nursing. Before her death, she was conducting comparative studies on air pollution in two B.C. centers.*

McCarthy is a graduate of the Vancouver General Hospital School of Nursing, U.B.C. and the University of California where she received a Master's in Public Health.

International health

As the membership chairman of the **Canadian Society of Tropical Medicine and International Health**, I am taking this opportunity to invite all nurses interested in tropical medicine or international health issues to join the Canadian Society.

As you may know, the Canadian Society of Tropical Medicine and International Health has emerged from a long association with the Canadian Public Health Association as the Tropical Medicine and International Health Division of the association. The Society is still closely affiliated with the CPHA.

Anyone interested in joining the Society is asked to contact:

*The Canadian Public Health Association,
1335 Carling Ave., Suite 210,
Ottawa, Ontario, K1Z 8N8.
—E.J. Ragan, M.D.,
Membership chairman,
Canadian Society of Tropical
Medicine and International
Health.*

Did you know ...

Canada will have a new national Bureau on Aging in operation by this Fall? The bureau, to be set up within the federal Department of Health and Welfare, will serve as a communications link between the federal government, provincial governments and organizations for the aged. It is expected to serve as a contact point for individuals and senior citizens' organizations.

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Designer Joe Famolare has invented a shoe that is meant to keep a smile on your face even if you must spend the entire day on your feet.

For comfort, there is nothing else like it. The patented four-wave sole serves as the perfect mediator between your foot and hard floors or pavement, absorbing shocks to the

heel and cushioning the arch as it rolls you forward in a graceful, extended stride.

The inner sole of this remarkable creation is anatomically contoured to support the foot and buoy up the spirits. Both inside and out, the Get There[®] is fashioned of the finest Italian glove-leathers. You will smile more in Get There[®] shoes.



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*The characteristic appearance of the Get There[®] sole is a trademark of Famolare, Inc.

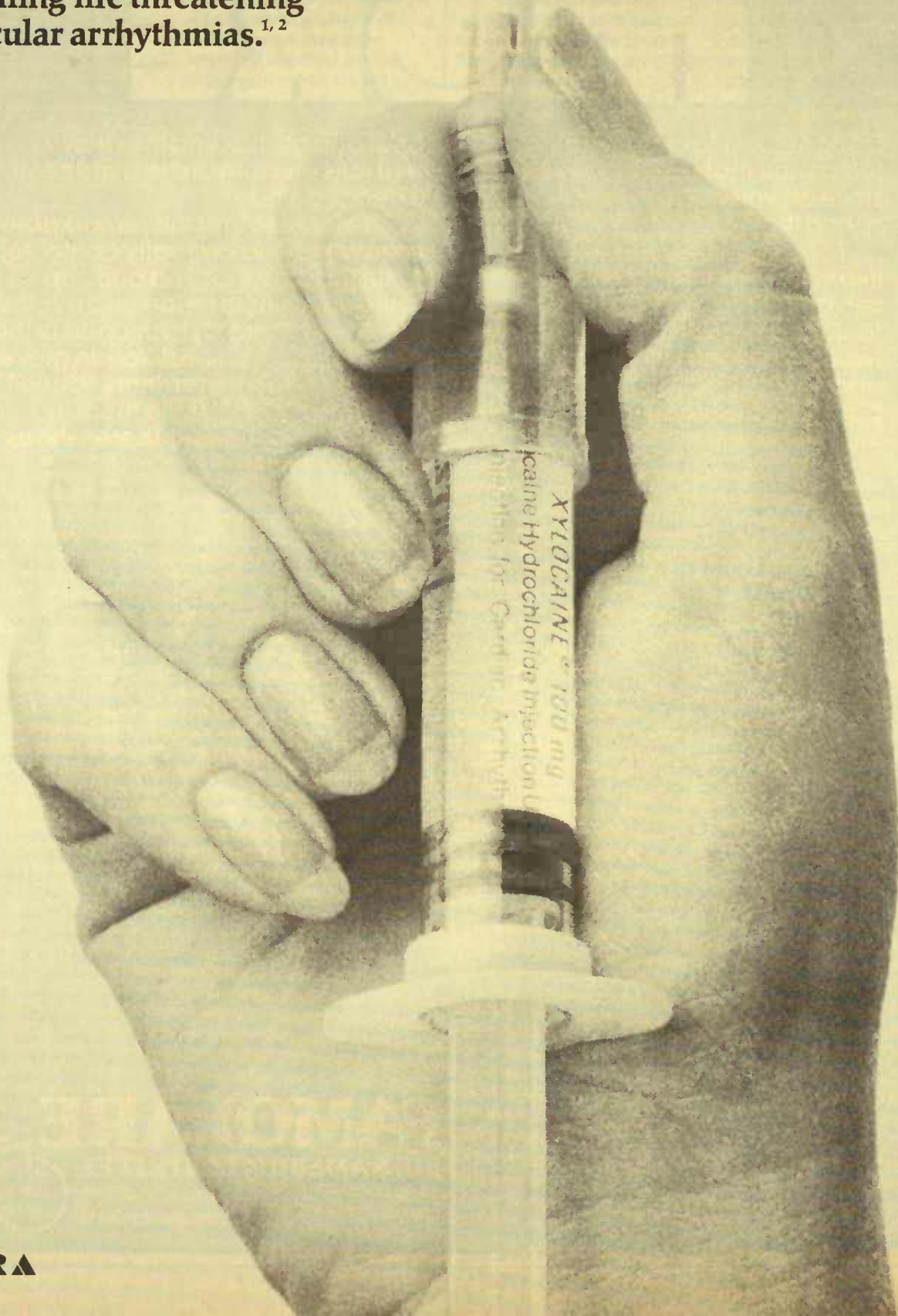
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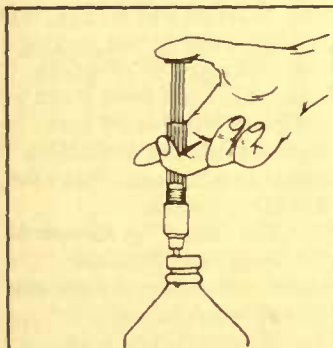
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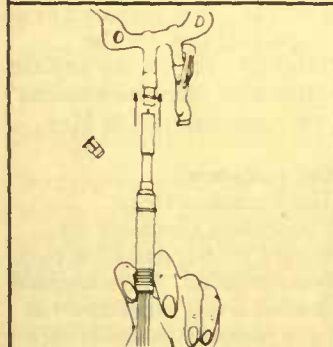
2. Xylocaine One Gram for Infusion.

Protection against recurring arrhythmias is provided by continuous intravenous infusion, that maintains steady therapeutic blood levels. Xylocaine One Gram prefilled units take the guesswork out of the infusion preparation and shorten set up time, when time is a critical factor.

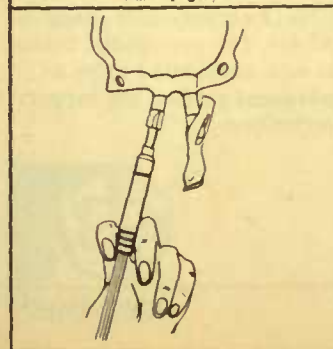
Methods of infusion preparation.



Glass infusion bottle.



Plastic infusion bag with Flex-A-Dapt.



Plastic infusion bag without Flex-A-Dapt.

INDICATIONS -

Intravenous administration: The intravenous administration of Xylocaine is indicated in the treatment of ventricular tachycardia and runs of premature ventricular beats occurring during cardiac manipulation, such as surgery or catheterization, which may occur during acute myocardial infarction, digitalis toxicity, or other cardiac diseases.

CONTRAINDICATIONS - Xylocaine (lidocaine) is contraindicated in patients with: (1) Known hypersensitivity to local anesthetics of the amide type; (2) Adams-Stokes syndrome, or severe degrees of sinoatrial, atrioventricular or intraventricular block.

The safety of Xylocaine (lidocaine) in the treatment of arrhythmias in children has not been established.

WARNINGS - Constant ECG monitoring is essential for the proper administration of Xylocaine intravenously. Signs of excessive depression of cardiac conductivity, such as prolongation of PR interval and QRS complex, and the appearance of aggravation of arrhythmias, should be followed by prompt cessation of the intravenous infusion.

It is mandatory to have emergency resuscitative equipment and drugs immediately available to manage possible adverse reactions involving the cardiovascular, respiratory, or central nervous systems.

PRECAUTIONS - Intravenous administration of Xylocaine is sometimes accompanied by a hypotensive response, and, in overdosage, this may be precipitous. For this reason the intravenous dose should not exceed 100 mg in a single injection, and no more than 200-300 mg in a one hour period. See DOSAGE AND ADMINISTRATION.

PRECAUTIONS - Xylocaine should be used with caution in patients with bradycardia, severe digitalis intoxication, or first or second degree heart block (See CONTRAINDICATIONS AND WARNINGS). Caution should be employed in the repeated use of Xylocaine in patients with severe liver or renal disease, since possible accumulation of Xylocaine or its metabolites may lead to toxic phenomena. In unconscious patients circulatory collapse should be watched for, since CNS effects may not be apparent as an initial manifestation of toxicity.

ADVERSE REACTIONS - Systemic reactions of the following types have been reported:

(1) Central Nervous System: lightheadedness; drowsiness; dizziness; apprehension; euphoria; tinnitus; blurred or double vision; nausea and vomiting; sensations of heat; cold or numbness; twitching; tremors; convulsions; unconsciousness; and respiratory depression or arrest.

(2) Cardiovascular System: hypotension; cardiovascular collapse; and bradycardia which may lead to cardiac arrest.

Adverse reactions tend to be dose-related. However, idiosyncratic reactions have been reported at low doses in some patients. Cross-sensitivity between Xylocaine and procainamide or Xylocaine and quinidine has not been reported.

SYMPTOMS AND TREATMENT OF OVERDOSAGE - Symptoms of overdose or idiosyncratic reactions are as described under ADVERSE REACTIONS.

Use of the drug should be discontinued if severe reactions occur. In the event of circulatory collapse, emergency resuscitative measures, such as oxygen, vasopressor drugs or cardiac massage, should be instituted. Cardiac pacemaker and defibrillator should be readily available. For severe convulsions, small doses of an ultra-short-acting barbiturate or a short-acting muscle relaxant (if the patient is under anesthesia) may be used.

DOSAGE AND ADMINISTRATION - (a) Single intravenous injection: The usual dose is 50 to 100 mg administered under ECG and blood pressure monitoring. This dose may be administered at the rate of approximately 25 to 50 mg/min. Sufficient time should be allowed to enable a slow circulation to carry the drug to the site of action. If the initial injection of 50 to 100 mg does not produce a desired response, a second dose may be repeated after 10 minutes. NO MORE THAN 200 TO 300 mg OF XYLOCAINE SHOULD BE ADMINISTERED DURING A ONE HOUR PERIOD.

(b) Continuous intravenous infusion: Following intravenous injection, Xylocaine may be administered by intravenous infusion at a rate of 1-2 mg/min. (approximately 15-30 µg/kg/min. in the average 70 kg patient) in those patients in whom the arrhythmia tends to recur, and who are incapable of receiving oral antiarrhythmic therapy.

Intravenous infusions of Xylocaine must be administered under constant ECG and blood pressure monitoring, and with meticulous regulation of infusion rate, in order to avoid potential overdosage and toxicity.

Intravenous infusions should be terminated as soon as the patient's basic cardiac rhythm appears to be stable or at the earliest signs of toxicity. It should rarely be necessary to continue intravenous infusion beyond 24 hours. As soon as possible, and when indicated, patients should be changed to an oral antiarrhythmic agent for maintenance therapy.

Solutions for intravenous infusion may be prepared by the addition of one gram of Xylocaine (i.e. contents of 50 ml single-use vial, or contents of 5 ml disposable transfer unit) to one litre of an appropriate infusion solution. Approximately a 0.1% solution will result from this procedure; that is, each ml will contain approximately 1 mg of Xylocaine.

AVAILABILITY - (a) For single intravenous injection: XYLOCAINE® (lidocaine HCl) 2% solution in 5 ml ampoules; or XYLOCAINE® 100 mg (lidocaine HCl) 2% solution in 5 ml pre-filled syringe. Each ml contains 20 mg, thus 2.5-5 ml will provide 50-100 mg.

(b) For continuous intravenous infusion: Add to 1 liter of appropriate diluent, such as 5% dextrose and water, the contents of XYLOCAINE® (lidocaine HCl) 2% solution in 50 ml single-use vial (20 mg/ml), or XYLOCAINE® lidocaine ONE GRAM (lidocaine HCl) in 5 ml disposable transfer unit containing 200 mg/ml. (Resultant concentration following dilution is approximately 0.1%, 1-2 ml/min. will provide 1-2 mg/min.)

Full prescribing information available on request.

References:

1. Lee, K.L. Wellens, H.J., Van Capelle, F.J. and Durrer D. N. Engl. J. Med. 291: 1324-1326, 1974.
2. Harrison, D.C., JAMA, 233: 1202-1204, 1975.

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MEMBER

PMAC

News

CNA offers support to federal nurses

The 1900 nurses who work for the federal government received the full support of their national professional association during their recent contract dispute with Treasury Board. The nurses, some of whom participated in rotating strikes and work-to-rule protests after they were in a legal position to strike, had been without a contract since December 1976.

A telegram, signed by CNA president Helen Taylor, was sent on July 17th to the Prime Minister, to Treasury Board president Robert Andras and other government officials directly involved in the dispute. The telegram urged that the Treasury Board "take immediate action for resumption of negotiations to resolve contract issues including those for nurses in the north (and) who are not receiving the same benefits as nurses in provincial locations."

The association also declared its support for Federal nurses in their demands for wage parity with provincial nurses. CNA executive director, Helen Mussallem, commenting on the association's position, said that conditions of employment and work should be determined by negotiations and other procedures set down by labor legislation between the Federal Government and the nursing group of The Professional Institute of the Public Service of Canada. The settlement of disagreements arising in connection with the determination of terms and conditions of employment should be sought through negotiations between the parties.

"The CNA believes that the nursing profession has the right and responsibility to define its functions. It recognizes that basic to the provision of a high quality nursing care is the adequacy of the nursing staff, conditions of work and an environment which promotes efficiency and individual satisfaction."

RNAO reacts to nursing ed study

The Registered Nurses Association of Ontario has called on the Ontario Government to postpone major changes in nursing education programs in that province until after the professional association completes a \$50,000 project designed to examine the functions and educational preparation of levels of nursing personnel.

"No major changes should be made in the diploma nursing program objectives or length until results of our nursing practice project are available next year," according to RNAO president Irmajean Bajnok.

The association was reacting to publication late this Spring of a study on two-year diploma nursing programs in Ontario and recommendations by the province's Ministry of Colleges and Universities concerning nursing education. In a brief to the Ministry, RNAO points out that "many of the conclusions and recommendations indicate that the study attempted to look at short-term solutions instead of looking at the philosophy and goals of nursing education."

According to RNAO's president, there is confusion between the educators and the employers. "The CAATs' objectives are to prepare diploma nurse graduates to function as generalists with basic nursing skills, while employers are expecting experienced practitioners. The study indicates that new graduates are being evaluated negatively on a different set of expectations, i.e., beginning practitioner vs experienced practitioner," she said.

"The fact that graduate nurses need some time to

adjust from the student role to the employee role makes them no different from other graduates. Orientation programs are one answer to this need," she continued.

While RNAO agrees that there may be some support for lengthening the diploma nursing program, they believe that educational program objectives and employer expectations must be clarified. "The answer is not to lengthen the program by merely "tacking on" additional hours or by dispensing with much needed vacation time," she said.

Nursing programs came under the auspices of CAATs in 1973. "It must be recognized that this approach to nursing education needs time to refine and mature. We strongly believe that making major changes to programs which have not been given a sufficient trial period for accurate and fair evaluation would be a mistake," says the RNAO president.

The study, "A Review of the Two-Year Diploma Nursing Program in Colleges of Applied Arts and Technology (CAATs) in Ontario," was prepared by a consulting firm for the Ministry. The review and the Ministry's recommendations were released late in May.

Did you know ...

The Canadian Heart Foundation standards for Basic Life Support CPR have been modified. The witnessed cardiac arrest procedure has been removed entirely. (See CNJ, February 1978, pages 42-43). The pre-cordial thump is now considered to be an advanced cardiac life support technique.

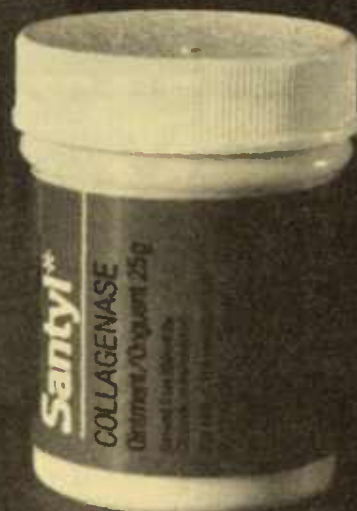


Federally employed nurses walk the picket line outside Treasury Board offices in Ottawa. The nurses work in veterans' hospitals, penitentiaries, outpost nursing stations in the North, on Indian reserves, at major ports of entry and on government-operated ships.

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(Varma, Bugatch & German, Surgery, Feb. 1973)

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— W. E. Zimmermann, Mod. Med. (U.S.A.), Apr. 1970

Santyl clears the way for healing:

"By clearing the ulcer base of necrotic, pyogenic material, healthy granulations are able to appear and subsequent epithelization of the ulcer can occur. I think the significant aspect of topical collagenase is its ability to rapidly debride the ulcer base so that in the meantime other causative factors can be determined, compensated and treated."

(M. Murray Nierman, "Cutis", Oct. 1976)

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Fully illustrated in colour, this brochure describes more fully how clinical trials have impressed physicians: in 140 debilitated male patients "... debridement of necrotic tissue and subsequent granulation and epithelization can be attained in decubitus ulcers that were previously considered refractory..."

(Helga Vetra, Derrick Whittaker, Geriatrics, Aug. 1975)

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Member



For brief prescribing information, see page 58

News

NBARN urges expanded role for nurses

Greater use should be made of nurse manpower to offset the soaring cost of health care, according to the New Brunswick Association of Registered Nurses. The association has issued an 18-page brief criticizing the Report of the Task Force on New Brunswick Health Care prepared by that province's health department.

In a preliminary statement issued immediately after publication of the Report, NBARN objected to the "acute-care, physician-oriented thrust" of the Report, terming the existing health care delivery system "myopic and inadequate."

The NBARN recommends that patients or clients have access to primary care, a health care delivery system in which the patient's initial contact is with a nurse.

The brief goes on to recommend that the health department utilize the Health Field Concept in its development and analysis of health services and policy.

Developed by the federal government and endorsed by the Provincial Minister of Health in 1974, the Health Field Concept is a four dimensional tool for analysing health problems, determining needs and choosing ways to meet these needs.

The association, furthermore, finds the terms of reference for a Physician Manpower Committee totally unacceptable. As an alternative, it suggests that a multidisciplinary committee of health services personnel should be examining the health needs of the population and the health delivery system structure, as outlined in the Report.

AARN issues statement supporting home care

The Alberta Association of Registered Nurses has released a position paper on home care stressing the need for a "concerted effort to help the public understand the value of home care as a level of care second to none." The focus of home care, according to the AARN, must always be on the individual's need and his well-being in his own natural environment.

The position paper makes the following points concerning the essential nature of home care and the role of the nurse in providing this service:

- Home Care provides a vehicle for the consumer to remain responsible for and involved in his own health care. This means of health care delivery must be available to individuals of all ages and must include promotion and maintenance of health as well as treatment and rehabilitation. Due to the potential of emergency situations, a 24-hour service must be available.

- The scope of nurses' preparation and their special concern to consider the total individual within his physical and social environment, makes inclusion of nurses as partners in planning health policies and programs essential. A nurse representing

the professional nurses' association should be a member of any decision-making committee of a Co-ordinated Home Care Program.

- Nurses are able to provide special emphasis in health care, that of assisting the individual to reach an optimal state of well-being, as opposed to only minimizing suffering. Nurses are well suited for a variety of roles within Home Care Programs, including co-ordinator, assessor of the consumers' potential for self-care or his need for nursing intervention or referral to another health professional, and the assessor who should assist the individual with his care.

Two careers in one.

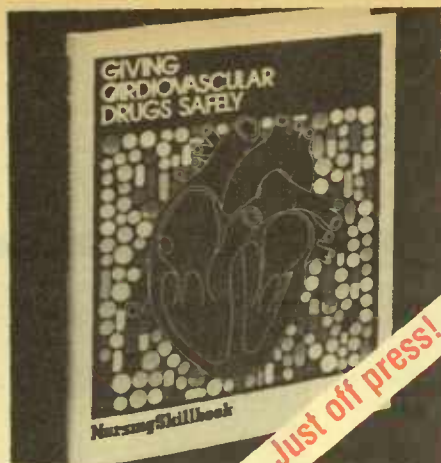
Have you ever thought of combining two careers in one? As a Canadian Forces nurse you could, because you would also be an officer, eligible for regular promotion, enjoying a minimum of four weeks vacation your very first year, free transportation privileges to many parts of the world, early retirement including a generous lifetime pension and a number of other benefits. The Canadian Forces will give you every opportunity to continue your nurse's training, while using the skills you already have in one of the many military medical installations in Canada or overseas. You might qualify for flight nurse's training or even for a complete doctorate study course.

If you're a graduate (female or male) of a school of nursing accredited by a provincial nursing association and a registered member of a provincial registered nurses' association, a Canadian citizen under 35 with two years' post-graduate experience in nursing, you owe it to yourself to enjoy two careers in one. Contact your nearest Canadian Forces Recruiting Centre or write to: Director of Recruiting and Selection National Defence Headquarters Ottawa, Ontario K1A 0K2



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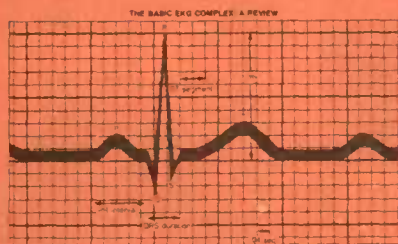




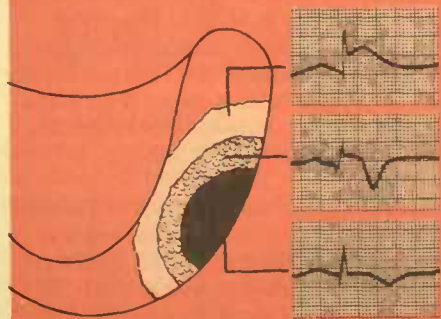
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Learn how cardiovascular drugs affect EKGs.



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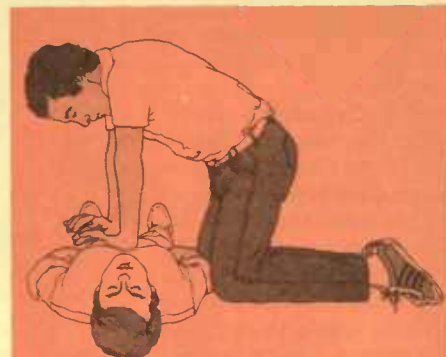
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Names and Faces

Canadian Nurses Foundation Scholars

Twelve Canadian nurses have been granted scholarships from the Canadian Nurses Foundation for the academic year 1978-79. A total of \$9,000 was awarded for doctoral studies related to nursing and \$30,500 for study at the Master's level.

The Canadian Nurses Foundation was established in 1962 by the Canadian Nurses Association to receive funds and administer fellowships for the preparation of nurses for leadership positions. A total of 163 nurses have been awarded scholarships under the program. CNF funding is voluntary and dependent on gifts, donations and bequests from individuals and organizations.



Joan Anderson of Vancouver, B.C. will receive \$4,500 to continue doctoral studies at the University of British Columbia. Her studies will focus on family interaction systems as they relate to preventive health care. She plans to return to her teaching position in the School of Nursing at U.B.C. upon completion of her degree.

Kathleen Rowat of Montreal will also receive \$4,500 to begin doctoral studies at Case Western Reserve University in

Cleveland, Ohio. She has been a faculty member of the McGill University School of Nursing and plans to return there after completing requirements for a Ph.D.



Deborah Irene Blair of Calgary has been awarded \$3,000 to begin study towards a Master of Science degree at the University of Calgary in the field of health care organization and health care delivery to the elderly. As a public health nurse, she has worked with a community geriatric service in Calgary and plans to continue in this field of practice.



Dawn Marie Hanson of St. John's, Newfoundland will receive a \$3,000 scholarship to continue Master's study in counseling in mental health at the University of Oregon, in Eugene, Oregon. She plans to practice counseling in mental health and to combine this with teaching at the university level in Newfoundland. This is the second year Dawn has been a CNF scholar.



Marthe Germaine Marie Tremblay of Hull, Quebec will receive a \$3,000 scholarship to continue Master's study in mental health and marriage counseling at St. Paul's University in Ottawa. Her main interest is in family mental health. Marthe plans to return to the Pierre Janet Hospital in Hull upon completion of her studies.



Paulette Falconer of Edmonton, Alberta has been granted \$3,000 to complete a Master's degree in gerontological nursing at the University of Rochester, New York. She plans to return to the Edmonton General Hospital, where she was assistant director of nursing, after completion of her degree.

Patricia Morden of Burlington, Ontario will receive a \$3,000 award to enter the Master's program in gerontology with emphasis on psychogeriatrics at McMaster University in Hamilton, Ontario. A former faculty



member of McMaster's School of Nursing, she plans to continue her involvement both clinically and academically in the improvement of health care of the elderly.



Isabel Caroline Milton of Beaconsfield, Quebec has been named winner of the Helen McArthur Canadian Red Cross Fellowship for graduate study. She plans to complete a Master's degree in community nursing at McGill University with the \$3,500 award. Upon completion of her studies, she hopes to practice in a community health center in Montreal and to teach nursing. This is the second year that Isabel has been a CNF scholar.

Carol Woods of Toronto, Ont., has been named winner of the Agnes Campbell Neill Memorial Award of \$1,200 and plans to complete a Master's degree at the University of Toronto in medical-surgical nursing with a focus on cardiovascular

nursing. Upon completion of her studies, she hopes to teach and engage in nursing research.



Karen Chalmers of Winnipeg, Manitoba will begin Master's study in community health at the University of Toronto with a \$3,000 CNF scholarship. She has held academic appointments and has worked in Nigeria under CUSO. Her goals for graduate study relate to expanding her understanding of primary health care and developing research skills.



Joyce Rainville of Montreal has been named the first winner of the Eleanor Jean Martin Nursing Award and will receive \$3,000 to study toward a Master of Science degree (Applied) at McGill University. Her particular focus will be family health and psychiatric nursing.



Rhea Arcand of Edmonton, Alta., has been awarded the White Sister Incorporated Scholarship Award (\$1,000) and \$2,000 from the Canadian Nurses Foundation. She plans to complete a Master's degree at the University of Alberta and then to teach in the Extended Care Nursing Program at Grant MacEwan Community College in Edmonton.

New Appointments

Norma Wylie (R.N., B.Sc., M.Sc.N.) has been appointed professor in the Department of Medical Humanities at Southern Illinois University School of Medicine.

Wylie has been project director of the Patient Care Demonstration Unit at the Victoria General Hospital in Halifax and a professor at Dalhousie University School of Nursing since 1974. Most recently, she has been working in the area of thanatology at the Victoria General where she was chairman of the Hospice Committee.

This new appointment will add further dimension to a nursing career which has included experience as a nursing sister with the Canadian Army Medical Corps, a nurse educator with WHO and a director of nursing at McMaster University Medical Centre.

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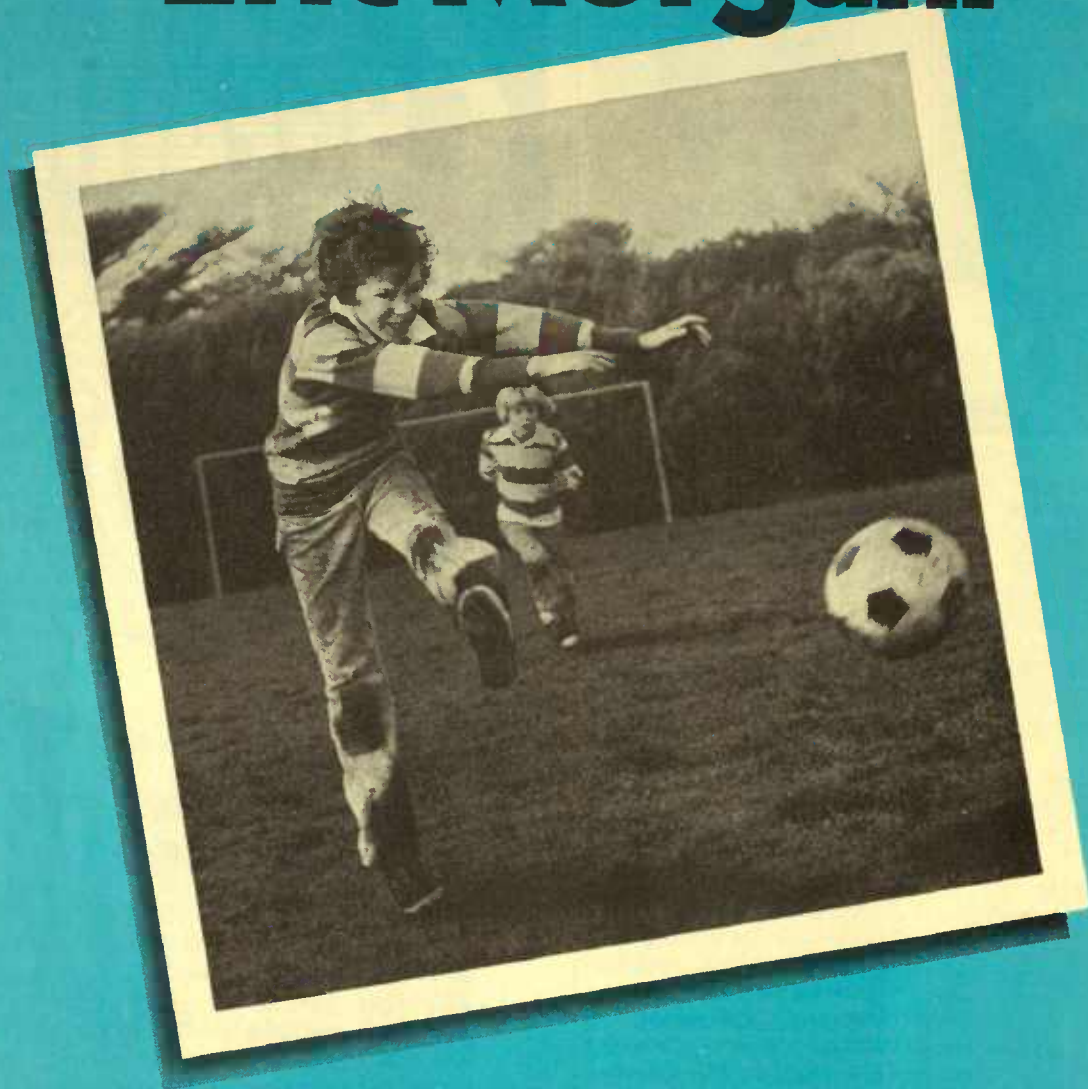
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 **CONNAUGHT INSULIN**

Calendar

September

Continuing Education Courses offered at the Leslie Campus of Seneca College in Willowdale, Ontario for the Fall 1978 term:

Keeping Current (certificate program) - an update in medical-surgical nursing; Geriatrics (Certificate program);

Pregnancy and its Impact on the Family;

Anatomy and Physiology Series;

Parasitology and Infectious Diseases. Contact: *Seneca College, Leslie Campus, 1255 Sheppard Ave. East, Willowdale, Ont., M2K 1E2.*

Second Regional Intensive Care Symposium to be held on Sept. 16-17, 1978 at Selkirk College, Castlegar, British Columbia. The topic, Acute Respiratory Care, is intended for physicians and nurses working in critical care settings. Guest Lecturer: Dr. Norman Traverse, Boston. Fee: \$35. Contact:

Department of Continuing Education, Selkirk College, Castlegar, B.C.

The Nurse as a Community Activist. A workshop sponsored by the Community Mental Health Nurses Association to be held on Sept. 29, 1978 at the Ramada Inn, Mississauga, Ont. Contact: *Community Mental Health Nurses Association, Workshop Committee, c/o Archway, 1316 Queen St. West, Toronto, Ont., M6K 1L4.*

Annual General Meeting of the Corporation of Nurses of the Montreal District. To be held Sept. 27, 1978 at the Sheraton Mount Royal Hotel, Montreal. Contact: *Jean-Noel Guay, 666 Sherbrooke Ouest, Suite 1004, Montreal, H3A 1E7.*

Advanced Course in Neonatal Nursing. A five-month program given at the Foothills Hospital in Calgary open to graduate nurses beginning Sept. 1978 and March 1979. Enrollment limited to eight. Contact: *B. Wright, Coordinator of Educational Services, Foothills Hospital, 1403-29 St., N.W., Calgary, Alta., T2N 2T9.*

October

Emergency '78. To be held at the Inn on the Park Hotel in Toronto on Oct. 12. Fee: \$15. Contact: *Dr. A Freiberg, 821 Coxwell Ave., Toronto, Ont., (416) 461-8051.*

Annual Meeting and Workshop of the Association of Remotivation Therapists of Canada Inc. To be held in Toronto at the Queen Street Mental Health Centre on Oct. 2, 3, 4, 1978. Fee: \$30. Contact: *Marie Gatley, Conference Chairman, 92 Upper Canada Drive, Willowdale, Ont., M2P 1S4.*

The Spiritual Care of Patients. To be held on Oct. 28, 1978 in the Nursing Building, University of Moncton, Moncton, N.B. Speaker: Barbara Olin. Sponsored by the Atlantic Nurses Christian Fellowship. Contact: *Jean Kimball, 195 City Line, Saint John, N.B., E2M 1L5.*

Occupational Health Services Conference to be held at the Four Seasons Hotel in Edmonton, Alta. on Oct. 16-17. Major emphasis will be on the functions, benefits, planning and staffing concerns in occupational health especially as it relates to small businesses. Contact: *Dianne Greenough, Millwoods Campus, Grant MacEwan Community College, Edmonton, Alta., T5J 2P2.*

Dynamics of Critical Care 1978. A two-day symposium on "Shock: resuscitation and complications". For all critical care and interested nurses. To be held Oct. 16-17, 1978 at the Holiday Inn, Downtown, Toronto.

Contact: *June Williams, Toronto Chapter, American Association of Critical Care Nurses, P.O. Box 37, Postal Station "Z", Toronto, Ontario, M5N 2Z3.*

Conference for Head Nurses and Educators. To be held Oct. 19-20, 1978 at Hotel Plaza II in Toronto. Topics include approaches to integrating nursing education and service, the beginning

practitioner etc. Contact: *Margaret Risk, RNAO, 33 Price St., Toronto, Ont., M4W 1Z2.*

Course in Rehabilitation Nursing for RNs and Registered Psychiatric Nurses to be held at the Wascana Hospital, Regina, Sask., from Oct. 16-Nov. 3, 1978. The three-week course stresses the importance of rehabilitation nursing in all types of health care fields and facilities. Contact: *Audrey Balon, Coordinator, 1978 Rehabilitation Nursing Course, Wascana Hospital, 23 Ave. and Ave. G, Regina, Sask., S4S 0A5.*

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YOU AND THE LAW



MINORS IN THE HEALTH CARE SYSTEM

Corinne Sklar

Minors, sometimes referred to in law as infants, are individuals who have not yet attained adult status. The nurse who encounters the minor patient in hospital, home, school, camp or clinic may well wonder what effect this status of "infant" or "minor" has on the delivery of health services.

At law, adults can freely contract for and consent to medical and nursing care (so long as no other legal disability is present, e.g. mental incompetence). Minors do not have such freedom. The law aims to protect those who have not yet attained adult status from their own immaturity. At common law, adult status is attained when age twenty-one is reached. This traditional age has been altered by provincial statutes, usually called Age of Majority Acts. The age of majority, or adulthood, may be eighteen or nineteen years depending on the specific provincial law applicable.¹ Some of the civil consequences of attaining the age of majority include, for example, the right to vote, the general right to enter contracts and thereby be responsible for them. Provincial legislation also may confer rights at ages below the age of majority. The right to drive an automobile or to leave school may be given to young persons at age sixteen. Generally, the attainment of the legal age of majority confers adult rights and responsibilities on the individual. Until such status is reached, the infant remains in the legal care of parents or guardians.

Under Canadian criminal law parents/guardians are responsible to provide the necessities of life for their children, i.e. medical, nursing and hospital services, as well as food, shelter, etc. Provincial Child Welfare legislation also imposes a legal duty on the parents/guardians to provide for the necessities of life and permits public intervention where such is not provided. In general, this legislation applies to children up to the age of sixteen years. Thus, the state assumes a protective role toward its minor citizens and will assume the parental responsibility to the child where parents neglect their duty.

Consent to Treatment

In March, 1978, the author examined the concept of consent from the standpoint of the adult patient.² The capacity of the minor patient to give consent was expressly omitted from the scope of this article since, although the basic principles of consent apply to both minors and adults, the status of infant (minor) raises some special considerations of which nurses should be aware.

Consent to medical or nursing treatment is a necessary prerequisite. The law requires consent to bodily interfere; if it is lacking then the legal wrong of battery is committed. Consent may be given expressly or may be implied (non-verbal assent). Any consent must be obtained voluntarily, must be relevant to the act performed and must be informed. The person giving consent must have the capacity to do so. Capacity refers to the patient's mental status as well as age. It is the age aspect that has relevance for minors.

Informed consent involves the capacity to understand the nature and consequences of the treatment as well as being able to reach an informed decision whether to accept or reject the proposed treatment. The patient must be old enough to appreciate the nature of the treatment, the consequences of accepting or rejecting it. Chronological age is therefore relevant: the sole consent or refusal of an eight-year-old to a tonsillectomy would not be valid. The level of emotional and intellectual ability of the patient is also relevant to the informed aspect of consent.

The test for capacity to give consent for medical treatment is whether the patient is old enough to appreciate the nature of the treatment and its consequences, and then come to a reasonable decision whether to accept or reject it.

Chronological age, though a relevant factor, is not the only determinant of a minor's capacity. While the law requires parental consent for children of tender years (the very young),

this requirement is less stringent as the minor reaches the adolescent years and approaches the age of majority (sometimes called the "age of discernment").

At common law there is no specified age fixed at which minors are absolutely and automatically incapable of giving consent. Instead, it becomes a question of opinion: Could the minor understand the nature of the treatment involved? Three categories of opinion exist concerning the common law capacity of minors to give consent to medical treatment for himself:

- all minors by reason of age alone are unable to give a legally effective consent,
- all minors under a vague "age of discretion" or discernment (usually sixteen years) are unable by reason of age alone to give a legally effective consent to medical treatment,
- no minor by reason of age alone is unable to give a legally effective consent to treatment.

This third opinion has gained favor with several legal writers³ who stress that capacity to appreciate the nature of the proposed treatment is the key element for consideration. A United Kingdom Committee examining the law regarding the age of majority found that although there was no rigid rule in English law rendering a minor incapable of giving consent for an operation, nevertheless there was no direct judicial authority establishing that the consent of such person is valid.⁴

In Canada there are two cases which provide the judicial authority validating such consent. Both cases were decided when the age of majority in the jurisdiction was twenty-one years. In *Booth v. Toronto General Hospital*,⁵ the court accepted as valid the consent of a nineteen-year-old to surgery on his nose. The court found that although only nineteen and not of the "highest intelligence," he was capable of taking care of himself.

In *Johnson v. Wellesley Hospital*⁶ a twenty-year-old had consented to slush treatment to remove acne scars from his face. His consent was directly in issue. Mr. Justice Addy, while accepting the common law age restrictions on infants regarding contracts and dealings in property, stated that a twenty-year-old, obviously intelligent and fully capable of understanding the possible consequences of a medical or surgical procedure as an adult, should be able to give a valid consent. He said:

Although the common law imposes very strict limitations on the capacity of persons under 21 years of age to hold, or rather divest themselves of, property or to enter into contracts concerning matters other than necessities, it would be ridiculous in this day and age, when the voting age is being reduced generally to 18 years, to state that a person of 20 years of age, who is obviously intelligent and as fully capable of understanding the possible consequences of a medical or surgical procedure as an adult, would at law, be incapable of consenting thereto. But, regardless of modern trends, I can find nothing in any of the old reported cases, except where infants of tender age or young children were involved, where the courts have found that a person under 21 years of age was legally incapable of consenting to medical treatment. If a person under 21 were incapable to consent to medical treatment, he would also be incapable of consenting to other types of bodily interference. A proposition purporting to establish that any bodily interference acquiesced in by a youth of 20 years would nevertheless constitute an assault would be absurd.⁷

Exceptions

There are three types of exception to the general disability of minors to give consent;

1. Emergency

The law with regard to emergency situations applies equally to adults and to minors. Where the situation is life/health threatening and immediate intervention is necessary and the person authorized to give consent is unavailable, then medical treatment is justified without consent. It is advisable to attempt

to make all reasonable efforts to obtain consent and to record that these efforts were fruitless and that intervention was necessary to protect life, limb or vital organ.

2. Emancipated Minor

This exception is seen more in the American cases. It involves a young person living outside of parental control, who is self-supporting and provides himself with the necessities of life in an independent existence. The patient in *Booth v. Toronto General Hospital* falls into this category.

It should be noted that the emancipated or liberated youth in *Booth* was independent of his parents economically. Increasingly, in the United States, the emancipated minor exception embraces the socially liberated youth whose parents still provide economic support. Such social autonomy refers to the minor's self-determination of lifestyle and companions. Thus in the U.S., emancipated minor refers to either social or economic autonomy or both. A Canadian court might accept such a broader view of "emancipation" today.

3. Mature Minor

This category of exception was developed and is applied largely in the United States where some states have codified the "mature minor rule" into law. The U.S. courts have chosen to recognize the minor's right to "self-determination" and have applied the mature minor rule usually to minors fifteen and over. The key to the rule's application is the minor's demonstration of the intelligence, understanding and independence of action that would justify the conclusion that he/she in fact is able to appreciate the nature and consequences of the treatment and can make a reasoned decision to accept or reject it. While *Johnson v. Wellesley Hospital* is not a Canadian enunciation or adoption of such a rule, the legal tests applicable are the same, namely, capacity to understand, appreciate and decide on the proposed treatment.

Thus it can be seen that the teenage patient's capacity to consent lies in a legal limbo: some would deny any such capacity while others would give such capacity commensurate with understanding. The former position (denial of capacity), requires parental consent and thus may preclude treatment in cases where the minor refuses to involve parents or the parents refuse consent. The second position (ability to appreciate), requires the nurse or physician to make a subjective determination of the patient's intellectual and emotional maturity. Throughout runs the requirement that the service in question must be for the minor's benefit. As well, the nature of the treatment is important, for the more major and involved the procedure, the more important it is to ensure the informed aspect of the consent (e.g. major abdominal surgery, long-term chemotherapy).

Parents may not arbitrarily withhold consent for needed medical services physically or psychologically necessary for the minor child's well-being. That is why Child Welfare legislation is necessary and is invoked to protect the best interests of the child. Children as individuals have rights too and health care workers should be especially cognizant of the expression of rights of these patients. The older the child the more relevant are his/her expressions of choice regarding his/her medical care.

Provincial Statutes

Provincial laws further complicate the uncertain position of the minor regarding consent. Legislation or accompanying regulations provide that there must be consent in writing before surgical operations in hospitals are undertaken. Parental consent is required for patients under a specific age, depending on the province. In Ontario, it is sixteen; in Saskatchewan it is eighteen. In Quebec, a child of fourteen or older may give a valid consent. Parental consent is mandatory for any younger child. Quebec physicians and hospitals must inform the parents where the child is to be "sheltered" for more than twelve hours or where extended treatment is being given.

In British Columbia, minors under sixteen require parental consent for any medical treatment except in emergencies. The consent of those over sixteen but still under the age of majority, is acceptable only where reasonable efforts to obtain parental consent have failed or there is a written opinion from a second physician concurring that the procedure is in the best interest of the health and well-being of the minor.

The scope of the legislation varies in each province: Quebec and B.C. provisions apply to medical care generally; Saskatchewan regulation limits the consent of an eighteen-year-old to in hospital surgical procedure only. The Ontario regulation applies to in hospital surgical or medical treatment. It is of interest to note that in Ontario and Saskatchewan the status of marriage confers the capacity to consent. Thus a married fifteen-year-old in Ontario is able to sign the hospital consent form. Marriage generally is emancipating, conferring adult capacity to consent to treatment.

In Canada we have not yet reached the broad legislative position attained in the United Kingdom. There, the age of majority is eighteen years. The Family Law Reform Act 1969⁸ expressly gives minors of sixteen the right to any surgical, medical or dental treatment without the necessity of parental consent. It also reserves the common law right of an under age minor to consent given the ability to understand the nature and effect of the procedure undertaken. In Canada, the minor does not generally have the sole right to self-determination regarding health care.

The best course of action in this uncertain area is to obtain parental consent wherever practicable. In the case of young children the necessity for such consent is obvious. The older and more discerning the child, the more appropriate it is to obtain consent from both parent and child. Parental consent should not override the express refusal of treatment by the older child.

Public health statutes generally enable school nurses to examine children without first obtaining consent. Thus height and weight measurement, eye and hearing testing and head examination for pediculosis proceed uncontested as do first-aid treatments for burns and scrapes. Parental consent is however necessary prior to embarking on immunization programs or any major examinations. And certainly parents should be informed of any treatment where there has been an accident, especially if follow-up care is required.

Most camps require parents to sign a consent form prior to the child's attendance at the camp. Given the distances from home and the expectation of parents that their child will be generally cared for at camp, such forms are of assistance. However, where there is serious illness or emergency, all efforts should be made to notify and consult with the parents rather than rely solely on a blanket, standard form signed consent.⁹ As well, where there has been any ongoing treatment or illness, parents should be apprised of the health care and treatments given their child while away from home.

Summary

The capacity of minors to give consent to medical treatment is not clearly delineated. Different provinces have different provincial age requirements and legal opinions vary. The safest position for the nurse is to always attempt to obtain parental consent. The younger the child the more necessary this requirement. In cases where a minor is approaching the age of majority, it is important to discern the level of intellectual and emotional maturity present since the capacity to understand and appreciate the nature and consequences of the treatment are necessary to the common law test of capacity of consent.

Legislation has attempted to define the capacity to give consent by age designation. The common law tests require a subjective professional assessment of such capacity: age and emotional maturity are not always co-relative. While exercising professional judgment and discretion, the professional must

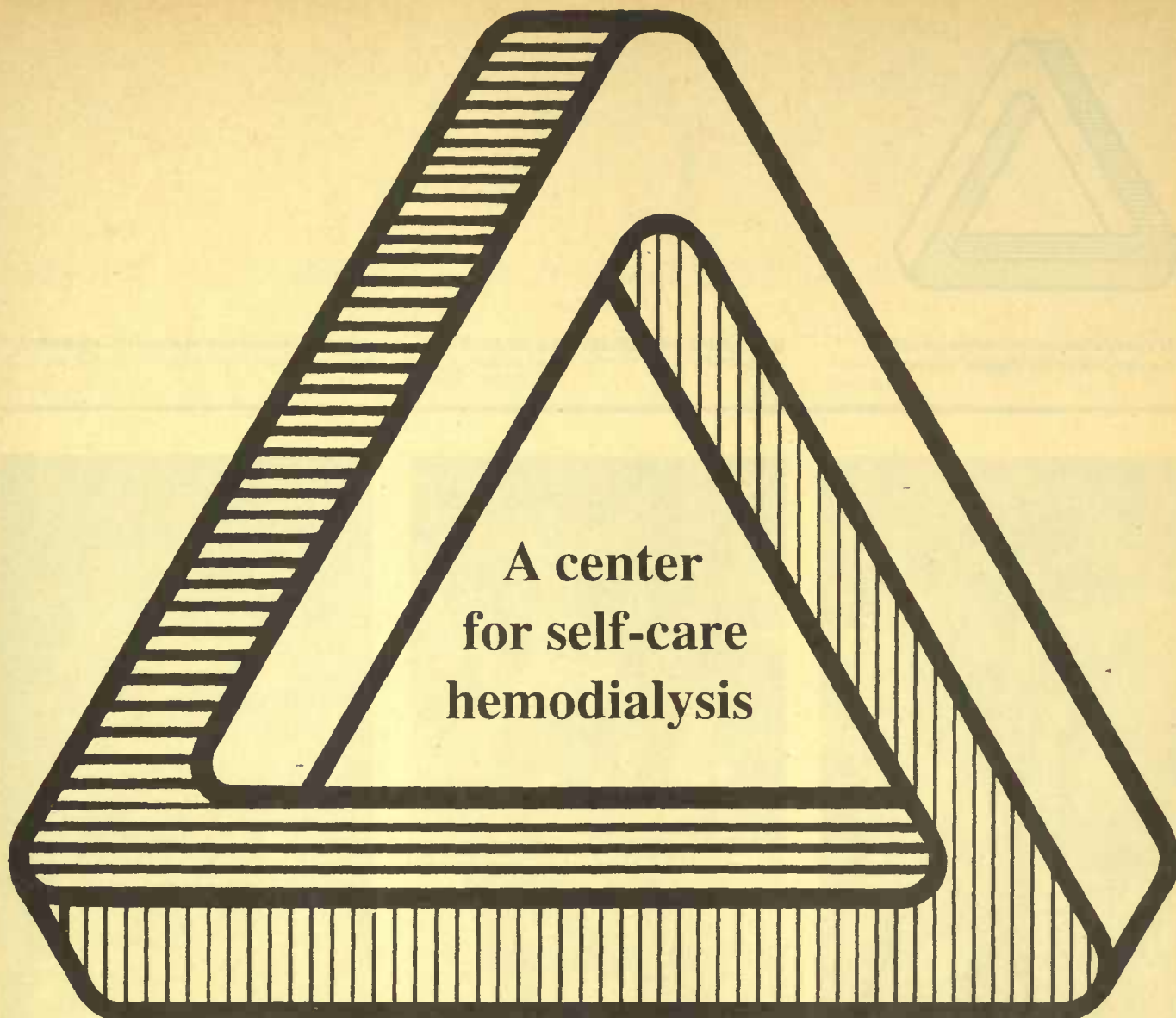
work within the statutory and common law limits applicable to his/her practice. But the law regarding the delivery of health care to minors especially the older adolescent remains a gray area and professional assessment and judgment are important considerations in the care of the minor patient. ❖

References

- 1 In British Columbia, Newfoundland, New Brunswick, Nova Scotia, Yukon, and the Northwest Territories the age of majority is nineteen years. In Prince Edward Island, Quebec, Ontario, Manitoba, Saskatchewan and Alberta it is eighteen years of age. In only three of the provinces has there been provision under legislation reducing the age of consent for medical treatment: British Columbia (sixteen), Ontario (sixteen - in hospital only), and Quebec (fourteen).
- 2 Sklar, C.L. "Legal Consent and the Nurse" (1978) Vol. 74 *Canad. Nurse* p. 24.
- 3 Tomkins, B. "Health Care for Minors: The Right to Consent" (1975) 40 *Sask. L. Rev.* 41.
- 4 Report of the Committee on the Age of Majority (1967), Cmnd. 3342 at 117. (The Latey Committee Report)
- 5 (1910), 17 O.W.R. 118 (Ont. K.B.).
- 6 (1971), 17 D.L.R. (3d) 139 (Ont. H.C.).
- 7 *Id* at 144.
- 8 *Family Law Reform Act* 1969, c.46, s.8. (United Kingdom).
- 9 If surgical intervention is required, as in Ontario O/Reg. 729 s.49, and parental consent is unavailable, the surgeon must record on the chart that the surgery was necessary to protect life, or limb or vital organ and that delay to obtain consent would so endanger the patient.



"You and the law" is a regular column that appears each month in *The Canadian Nurse* and *L'infirmière canadienne*. Author Corinne L. Sklar is a nurse and recent graduate of the University of Toronto Faculty of Law.



A center for self-care hemodialysis

The Queen Mary Veterans Hospital* in Montreal began a hemodialysis program in May 1972 to replace a peritoneal dialysis program. Since that time, there has been an expansion in the facilities and a marked improvement in the program offered to end-stage renal failure patients. Perhaps the most important development, according to the authors, has been the establishment of a self-care center dialysis program.

Clarice Reliszko
Paul Barré

Our original dialysis unit started in a small room measuring about 25 x 9 feet (225 square feet). We had one dialysis machine for three patients and a staff of four nurses, one nephrologist and a rotating renal resident.

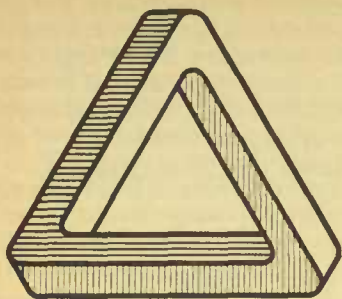
Six months later, we obtained a second dialysis machine and a more sophisticated 6-bed dialysis unit was opened covering an area of 90 x 20 feet (1800 square feet). By 1974, we had nine patients coming to the unit for treatment and three more dialysis machines were added to our supply. An isolation room

completely separated from the main unit was also added for Australian antigen patients.

In the spring of 1975, with an increased patient load and a limited budget for a staff of six nurses, a nurse with previous experience in home care dialysis proposed the idea of "self-care" or "limited care dialysis." With some hesitation, the nephrologists in charge of

the unit agreed to the training of patients to their fullest potential and the program was launched. Self-care dialysis as a form of management for end-stage renal failure has been carried out for years in the United States and Europe but the implementation of such a program at the Queen Mary Veterans Hospital is the first to our knowledge in Canada.

**Since the time of writing this article, the hospital name has been changed to Centre Hospitalier Cote des Neiges.*



This young woman, recently trained in self-care, primes the dialysis machine.

Here, she is carefully checking for air in the tubing.

All set to initiate her own dialysis treatment.



We selected two patients, the most recent patient to the unit and the patient who had been on treatment for the longest time, as candidates for the pilot project and applied the same teaching techniques used to train home dialysis patients. The patients were given all the time they needed to learn how to prepare the machines and equipment in order to initiate their treatment. The unhurried atmosphere made them feel relaxed and their motivation increased with the satisfaction of being able to control their treatment and participate in the decision making. Because the pilot project proved to be very successful for these two patients, other patients have been taught to perform self-dialysis treatments.

The teaching program

The patients are taught on a one-to-one basis for a two or three month period. The pitfalls they may encounter during dialysis, both mechanical and physiological, and the appropriate steps required to avoid or correct such incidents are repeated over and over until they feel comfortable with the artificial kidney.

Emphasis is placed on the potential dangers of air embolus, over or under heparinization, the proper control of blood pressure while on the machine, as well as a knowledge of the correct bath concentration and bath temperature. In addition, patients are given an explanation of their own kidney disease, the theoretical function of the artificial kidney, the necessity and importance of following a diet and the indications for their various medications.

The actual training period is from 6-8 weeks. By the end of that time, they are able to hemodialyze themselves with limited supervision. The one procedure in self-care which seems to frighten most patients prior to completing their training, is the insertion of the needle into the arteriovenous fistula. To date however, all but one patient have been successful in overcoming this fear.

In November 1975, we opened a "self-care evening program" with two patients and a nurse. Now nine patients come in for evening dialysis.

Why self-care

The objective of our program is to provide a space for trained patients to dialyze themselves in a hospital facility.

Inserting the fistula needle is initially one of the most feared procedures for many patients on self-care.

Patients on the self-care program learn to take periodic checks of their blood pressure during dialysis.

This patient is taking a blood sample after cleaning and dressing his shunt before dialysis.



Since we started the self-care program, 22 patients coming from various hospitals in Montreal have been trained. Their rehabilitation has been excellent; 15 patients have returned to full-time employment. Two patients, aged 63 and 57, have retired; another cannot find work in his field; another patient has returned to college. Three patients are presently being trained and there has been one patient who preferred to return to the dialysis center. In all, four patients have received renal transplants. Even though we were initially sceptical about some of the patients' learning abilities, any reasonable candidate was trained and for the most part the patients have become very competent. It is of interest that several patients who at first, showed little or no interest in the program, later became very enthusiastic, skilled and precise at carrying out their own dialysis treatments.

At the present time, two-thirds of the hemodialysis patients (17 patients) are on the self-care program. Because the psychological and medical benefits far outweigh the disadvantages, we plan to expand this aspect of treatment for end-stage renal disease patients. ♡

Because some patients lack space at home or a suitable partner to help with treatment at home, they are not suitable for home dialysis treatments. The benefits of home dialysis such as greater rehabilitation, resumption of previous activities, greater patient independence and well being and the feeling of control over their machine and not the machine controlling them are also experienced by patients on self-care.

From a timid experiment, two and a half years ago, we have progressed to a formal, comprehensive program that is taught by the unit nurses. We have developed a patient manual and a training guide manual adapted to our needs and equipment. We feel confident that the majority of patients can be dialyzed safely with considerable economic, psychological and medical benefits.

Clarice Reliszko (R.N.) is a graduate of Far Eastern University School of Nursing, The Phillippines. She has been a member of the Queen Mary Veterans Hospital hemodialysis unit for the past three years and has trained several patients in the self-care hemodialysis program.

Paul Barré (M.D., F.R.C.P.(C)), a graduate of the University of British Columbia, is an assistant professor at McGill University. He is a member of the departments of nephrology at the Royal Victoria and Queen Mary Veterans Hospitals in Montreal and coordinates the hemodialysis program at Queen Mary.

Frankly Speaking

**STANDARDS:
are they
really
necessary?**



Deidre Blank

Are you nursing more, but enjoying it less? How often lately have you heard yourself saying: "The pressures are too great. Administration expects too much. We never have enough staff. We don't get the recognition we deserve." Or, "Nursing terminology is getting too confusing and complicated."

If this sounds familiar, take heart, you are not alone. More and more nurses today are asking what, exactly, is our role in keeping people healthy and caring for those who are sick. And, if nursing is to respond to the needs of society in the future, we had better find an answer to that question pretty soon.

What can we — as individuals and as a profession — do to help in more clearly defining the role of the registered nurse? What kind of help can we expect from our professional association?

Nurses *do* make a difference to the health of Canadians. Do we realize the extent of that impact? Numerically, of course, we are the strongest category of health worker. In addition, of all the health personnel, we spend the greatest amount of time with the client. As nurses, we make more and more independent decisions every day. In short, we have a really unique opportunity to make a significant contribution to the health and well-being of many thousands of people.

What are *you* doing to take advantage of this opportunity? Do you practice mainly by intuition, trial-and-error, "order by the physician only," or, "that's the way we always did it in the past" approach? If your answer is yes to any one of these responses, then chances are that you are not getting the most out of the "R.N." signed after your name. And, what's more, neither is your client!

Your professional association can help

In the past, the nursing profession has had no trouble in demonstrating its accountability to administration, medicine, pharmacy, dietetics, housekeeping, and many other areas. But nursing is changing and can no longer afford to hide behind past chauvinism and the hierarchies that exist within the health care system. If nurses

expect to legitimize nursing practice, then we must demonstrate our accountability to our clients. How can we accomplish this?

A good place to begin is by adhering to the standards of nursing practice that are determined by our own professional associations. Setting rigorous standards for the profession and helping to enforce them is a major and well-known function of any professional association¹. This can also be accomplished on a personal level.

According to Labelle, "Credibility as a respected practitioner comes from demonstrated excellence based on sound knowledge ... For individual nurses accountability means answerability and responsibility for outcomes of nursing actions ..."² It means that each nurse is consciously working towards a certain degree of excellence in his/her nursing practice.

What are professional associations doing to help nurses achieve this desired degree of responsibility and accountability in their practice? On the national scene, the Canadian Nurses Association recently initiated a joint project with Health and Welfare Canada to develop national standards for nursing practice. This project is a reflection of both the moral responsibility of government to guarantee quality nursing care to society and the professional responsibility of the CNA "to promote high standards of nursing practice in order to provide quality nursing care for the people of Canada."³

At the same time, nurses' associations in the provinces and territories have also been making progress in this area. From British Columbia to Newfoundland, professional associations are beginning to come to terms, each in its own fashion, with the need to develop and implement methods of evaluating patient care and providing quality assurance.

It would appear that we are at last beginning to accept the need to critically evaluate the quality of our nursing practice.

Why standards?

Why do we need standards? How will standards help us in our practice? How will they help the consumer?

1. **Standards** provide us with a systematic and comprehensive approach to our nursing practice that is the key to successful decision making. Effective systematic reasoning is one of the most powerful tools we can use to effect change and improve our nursing practice. Nurses who cannot systematically attack problems often waste a lot of time and energy in making decisions which may be ineffective and which they cannot justify.⁴

2. **Standards** help us to evaluate the quality of our nursing practice. When a nurse is required to evaluate a policy, procedure, or nursing practice, it is important that a systematic and comprehensive approach be used. This allows us to reconstruct our rationale and critically analyze our nursing care in open review.⁵ It also helps us to recognize what kind of contribution nurses are making to the health care of consumers in this country.

3. **Standards** reassure the consumer that quality of care is an important part of nursing practice. Outlining expectations for nurses in writing tells the consumer that we care enough to give the very best nursing care.

4. **Standards** can be utilized to promote increased consumer involvement. They can reflect not only the consumer's right, but also his responsibility to be involved in his personal care.

The Manitoba experience

To illustrate some of the work involved in the setting of standards let's look at how one professional association addressed the issue. In 1974 the Manitoba Association of Registered Nurses (M.A.R.N.) decided to proceed with the development of standards. The association believed that some standards are basic to any nursing encounter and therefore decided to develop nursing practice standards of a general nature.

Our first task was to develop a written statement of nursing and a definition of nursing practice. Identifying our philosophy and reaching agreement on what we believed about nursing practice and the role of the nurse created a basis for writing the standards.

ASSESSMENT

STANDARD: *Assessment of the health care needs of an individual/family/ community is based on interpretation and validation of health data and compared with recognized norms to determine a nursing diagnosis.*

Figure 1

Structure Criteria

The health care setting where nursing occurs provides for:

1. Written expectations outlining the scope of nursing responsibilities.
2. Accessible resources for assessment.
3. Accessible recognized norms for comparison.
4. Recording of assessment data.
5. Recording of nursing diagnosis.

Figure 2

Process Criteria

The nurse:

1. Validates assessment with:
 - 1.1 individual.
 - 1.2 family.
 - 1.3 community.
 - 1.4 health personnel.
 - 1.5 significant others.
2. Utilizes resources available for comparison.
3. Records assessment data.
4. Interprets data to determine nursing diagnosis.
5. Records nursing diagnosis.
6. Identifies immediate needs.
7. Assesses recognized norms.
8. Compares nursing diagnosis with recognized norms.
9. Encourages self-assessment in the individual.

Figure 3

Outcome Criteria

Individual/ client receiving nursing care:

1. Participates in validation of data.
2. Indicates immediate needs have been met.
3. Gains knowledge of health status.

Family/significant others:

1. Participate in validation of data.
2. Gain knowledge of individual's health status.

A committee was also appointed to plan the development and implementation of standards. One of its first tasks was to initiate a comprehensive review of the literature to obtain facts, values, and beliefs about nursing practice as identified by various nursing experts. Letters were sent to individuals and groups in Manitoba and throughout Canada requesting feedback on standards activities and this information was classified, analyzed, and summarized.

The next step was the selection of a framework for the standards, and the decision to make nursing process the primary component of this framework, as well as the basis for each standard. This meant that nurses could offer each client a systematic and comprehensive approach to his care. The nursing process can also be applied in any setting by any nurse.

To further assist us in writing the standards, we added a second component composed of structure, process, and outcome criteria.⁶ Each of these criteria was then applied to each standard identified by the association.

These criteria specify the behaviors and resources necessary to achieving each standard. As nurses, we can use the criteria individually or collectively to evaluate the quality of our practice.

Structure, process and outcome

Standards of nursing practice outline expectations of nurses in their daily practice and as such yield the necessary direction for providing and evaluating our nursing care. We can more easily appreciate this direction if we look closely at each of the three criteria outlined earlier.

1. **Structure criteria** refer to the health care settings in which we nurse and the resources needed to meet the health needs of our clients; they are the essential supports which must be provided in settings where nursing is practiced.

Our role as nurses is to identify what we need in a given setting to administer good nursing care to our clients. To illustrate this point as it relates to the Assessment Standard (See Figure 1), you might ask yourself the following

questions:

- Do I have a job description which clearly outlines what my responsibilities are?
- Are my responsibilities consistent with the practice of nursing?
- Do I have the equipment, material and/or human resources that I need to give good nursing care?
- Is there provision made for the recording of important information about my client's state of health?

Standards which incorporate structure criteria recognize that the setting must provide essential supports if nurses are to implement quality care. It also acknowledges that things may not always go right even though you have tried your darndest to give good nursing care. Outside forces such as the structure within which you nurse may affect the care that you are able to provide. However, structure criteria alone cannot provide a comprehensive evaluation of our nursing practice so we must also look at process and outcome criteria.

2. **Process criteria** relate to the nature and sequence of our nursing activities. The statements under this section identify what we should be doing in our everyday practice of nursing. To determine whether or not you are meeting the Assessment Standard (See Figure 2) as it relates to your nursing activities, you might ask yourself the following:

- Do I verify my nursing assessment with appropriate sources?
- Do I document in writing what I find to be significant to the nursing care of my client?
- Does my assessment indicate the need for nursing intervention?
- Have I documented my client's priority needs?
- Are my nursing activities to date consistent with my client's health needs?

It is in this part of the assessment standard that we identify whether or not nursing intervention is required. Although the standards provide direction, it is our judgment in applying these standards that remains the crucial element in nursing activities.

Now that we have applied our nursing skills and knowledge, what effect does this have on our client? To answer this question, we must look at our third criteria.

3. **Outcome criteria** indicate the client's state of health and/or level of knowledge as a result of purposeful intervention. Nursing practice plays a significant role in helping recipients of health care to reach desired outcomes. To analyze what effects your nursing care has on your client, you might ask yourself the following as it applies to the Assessment Standard (See Figure 3):

- As a result of my nursing actions, is my client or family involved in verifying information?
- Has my client indicated that his basic needs have been met?
- What does my client or family understand about his present state of health?

Outcome criteria prove one thing. From the beginning, involvement of nurses and consumers is essential to the development and implementation of realistic and achievable standards for assuring quality nursing care to society.

Donabedian, a leading researcher in health care evaluation, suggests that we do not know enough to base any program for assuring quality care exclusively on any one of structure, process, or outcome criteria. He stresses the need to look at all three criteria simultaneously. He further suggests that we design our evaluation systems to give information about the specific relationships between structure, process, and outcome. This in turn will help us to understand what effect the health care setting has on nursing practice and the extent to which our nursing practice contributes to desired outcomes for our clients.⁷

YOU make the difference

What difference can standards of nursing practice make in your day-to-day practice? Well, by using a standards framework based upon the nursing process and structure, process, and outcome criteria, you can systematically and comprehensively assess, plan, implement, and evaluate your nursing practice.

You can also analyze critically what effect the health care structure is having on your nursing practice as well as the impact you are having on your clients. As nurses we must be able to justify to society why our nursing services are required and what effect these services are having on the client.

Standards can also help to promote a common language for the profession and strengthen communication among nurses. We have all heard complaints about the use of jargon in nursing. Surely, effective, meaningful communication can only serve to enhance nursing practice.

At the same time, standards outline our specific nursing responsibilities and accountability to society. Standards identify for the consumer what he can expect from nurses as well as when and how he is to be involved in decision making as it relates to nursing care. Finally, standards promote both society's and our perception of nursing as being capable of making a valuable contribution to the health care system.

The validity of that contribution is your choice. The impact that standards of nursing practice has is up to you!

Deidre Blank, the author of "Standards: Are they really necessary?" was until recently nursing consultant — standards with the Manitoba Association of Registered Nurses, a position she held for two years. As standards consultant, she was responsible for the development and implementation of generic standards of nursing practice throughout Manitoba.

Before coming to Manitoba, she was instructor in nursing in the Department of Baccalaureate Nursing at Thomas Jefferson University in Philadelphia, Penn. Other professional experience included positions as coordinator of nursing education at St. Christopher's Hospital for Children in Philadelphia and assistant clinical instructor in the School of Nursing at Thomas Jefferson University. A graduate of the School of Nursing, College of Applied Health Sciences, Thomas Jefferson University, Deidre received her Bachelor of Science in Nursing from the University of Pennsylvania and her Master of Science in Nursing from the same university.

While living in Manitoba, Deidre researched and prepared a collection of ethnic specialty recipes which has been published under the title of "Winnipeg's Culinary Mosaic."

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Mothers have needs too

"To me there is nothing more rewarding. I feel that I have found my niche in life."

"This past year has been very difficult and unhappy for me. 'The terrible twos' describes it exactly."

"I often cry at night because I have been so miserable with them all day. I resolve to do better the next day."

... It is almost as if we believe that once you are a biological mother you will automatically become a virtuous model of self-sacrifice and devotion.

L. Joan Brailey

In the course of our work as nurses we often meet with preschool children and their mothers. During these contacts our attention is usually directed to the needs and behavior of the child. The mother's needs are often forgotten in spite of the fact that her satisfaction with her role greatly affects the mother-child relationship and the characteristics the child will eventually develop.

When parents register a child for school or admit a child to hospital they are, in a way, unveiling the product of their home to the scrutiny of society. These situations can provide the nurse with great opportunities for in-depth teaching and counseling. These may also be opportune times for the nurse to focus her attention on the needs of all the family members and on the development of the family unit as a whole.

Learning to be a mother is very different today than it was fifty or even twenty-five years ago. "In the past, when several generations lived together or nearby, parents or grandparents or cousins or aunts were always on hand to advise and aid young parents in raising their children."¹ Today young families are often removed from the supportive day-to-day relationships of the extended family and yet, our society provides very few alternatives for them.

It appears we simply subscribe to the myth that motherhood is an instinct welling up in all women who give birth to children. We put mothers and children in isolated households, give mothers almost exclusive responsibility for the care of their children and expect them to give tender loving care around the clock.²

It is almost as if we believe that once you are a biological mother you will automatically become a virtuous model of self-sacrifice and devotion. Unfortunately, many a young woman believes that this will happen. If it does not and she finds herself resenting her child she can feel guilty; a failure as a mother.

Because we perpetuate this myth of joyous perfect motherhood, mothers can often feel unable to express their feelings of confusion, inadequacy and unhappiness. A new mother needs to be able to share her feelings about motherhood. She needs help from a caring and understanding person.³ If she can find support she is more likely to be able to accept herself as normal and learn to cope with a sometimes difficult situation.

Mothers, like children, grow and develop in their roles. They are constantly adapting to changes in the family and in themselves. Duvall considers the motherhood of a preschool child a distinct developmental phase for women.⁴ I chose one element in this phase, achieving confidence in their role as mother of a preschool child, as the basis for one part of my study.⁵

The Study

I wanted to investigate:

- If mothers have concerns about their mothering skills or knowledge.
- If mothers asked for help regarding these concerns, and, if so, from whom?
- If they received advice, was it helpful?
- If mothers believe that individual counseling or group classes would be helpful in improving their mothering skills and knowledge.

Fifty married women who were living with their husbands and whose oldest children were between two and four years of age were selected from six nursery schools in a borough of Metropolitan Toronto. I interviewed these women, for about one hour each, in their own homes using a structured interview schedule. Table one shows several selected characteristics of this group of mothers.

Discoveries

The mothers responded enthusiastically to this opportunity to express their views about motherhood. Many of these women did have concerns about their mothering skills or knowledge. Although they were most concerned about their children's emotional needs and ways to handle their children's behavior there was considerable variation in the number and kinds of behavior which concerned them. (See Table two)

The behaviors which most frequently concerned these mothers were actually common characteristics of children between two and four years of age (e.g. 'being contrary or stubborn'). Perhaps their concern indicated that they did not understand the child's developmental stages. Many mothers expressed a desperation for guidance in overcoming their child's age-related stubbornness in the areas of eating, sleeping and toilet-training.

The women I spoke with were relatively well-educated and very interested in the quality of their mothering skills. Yet only 11 of the 50 were aware of the parent education classes that were available in their community or that they could ask a community health nurse for support. There appears to be an immediate need to establish the image of the community

Table One

SELECTED CHARACTERISTICS OF MOTHERS

Characteristics	Number of mothers	Percent of mothers
Age group		
21 to 25 years	8	16
26 to 34 years	36	72
35 and over	6	12
Number of children		
two	32	64
one	18	36
Highest level of education		
grade 10 or 11	5	10
graduate of high school	21	42
post-secondary school	16	32
university	8	16
Country of birth		
Canada	38	76
other	12	24
Employment		
none	29	58
outside the home	14	28
in the home	7	14

Table Two

MOTHERS' CONCERNS REGARDING CHILDREN'S BEHAVIORS

Concerns	Number of mothers	Percent of mothers
Being contrary or stubborn	28	56%
High strung or easily upset	19	38%
Waking up at night	15	30%
Wanting too much attention	15	30%
Overly cautious or fearful	12	24%
Wanting too much comfort or support from the mother	11	22%
Reluctance to go to bed	10	20%
Being shy	10	20%
Being disobedient	10	20%
Being too active	9	18%
Fighting with other children	3	6%
Other (e.g. whining, jealousy, temper tantrums)	15	30%

health nurse as a knowledgeable, helpful person. Wider publicity for home visiting services and parent education classes also appear necessary. Preschool registration might be an excellent time for advertising and organizing parent groups.

Mothers felt more confident caring for their children's general physical needs (food, clothing and rest) than handling their behavior. But only 32 percent of the mothers I interviewed felt confident in caring for their child when ill. Several mothers told me they did not know how to read a thermometer. One mother related a recent experience; she and her husband had tried for hours one night to bring down their child's fever with sponging following the doctor's brief telephone instructions. The couple had felt completely unprepared and panicky. This kind of situation can serve as an indication that nurses should take a more active role in introducing care of the sick child when counseling mothers.

Advisors

I asked each mother whom they had approached for advice about their child's behavior and/or development. I also asked them if they had found this advice useful. Some mothers objected to the word 'advice.' They said they often compared experiences with others and sought reassurance by asking questions like, "Is this stage Johnny is in ever going to end?" or "Is my child the only one who does this?"

Friends were the source of advice used by the greatest number of mothers and yet they were often found to be the least helpful. Slightly more than one-half of the mothers had consulted a doctor regarding behavioral questions and of these women 86 percent considered the advice helpful. Many others said they only asked the doctor questions about the child's physical health. Six mothers had consulted professionals other than doctors. All of these mothers, including the four who had consulted public health nurses, considered the advice helpful. The 11 women who had attended parent education groups said they found these sessions very helpful. But as I mentioned a little earlier, the other mothers were entirely unaware of the services offered by public health nurses.

My findings regarding the sources of advice used by the mothers have many implications for nursing. Some mothers told me they did not like to feel they needed advice. Perhaps these women would be reluctant to attend parent education groups or to ask a community health nurse to visit under any circumstances. But if we look at the wide

popularity of prenatal classes, with their emphasis on anticipatory guidance, there may be some hope for parent education groups. If preschool parenting classes were held during the child's first two years of life and/or were routine around the time of preschool registration, then perhaps the discussion could be anticipatory in nature and therefore more acceptable.

The women I spoke to often compared their mothering experiences with other mothers and said these conversations usually reassured them. But, at the same time, these women said they thought professional advice would be more helpful. This information points out how important it is for nurses heading parent education groups to allow ample time for discussion and the sharing of experiences while at the same time maintaining some degree of professional input and guidance.

Some mothers said they were reluctant to mention their concerns to their doctors for fear of being thought of as "silly" or "a neurotic mother." Both nurses and doctors should make a special effort in every contact with mothers and their children to discover the mother's real concerns. This study has shown that mothers will often not mention their concerns because they see them as inappropriate subjects for professional discussion. These mothers may cloak their concerns with a casual, offhand manner. Nurses need to be aware of this or they might miss expressions of serious concern.⁶

Since the women I spoke to said they discussed their concerns more readily with friends than with professionals nurses should try to adopt a friendly, close manner when working with mothers. It would be only natural for mothers to feel more comfortable chatting with a relaxed, understanding nurse than dealing with a rigidly structured professional. It is important to note that although only four mothers had asked community health nurses for advice, all four considered this advice helpful.

I asked all the mothers if they thought they would find individual counseling or group classes on several topics useful. The mothers' reactions to this question are shown in Table three.

Ninety percent of the mothers thought that counseling or group classes in at least one aspect of child care would be of some help. Once again the two topics generating the most concern were children's emotional needs and the handling of child behavior.

Table Three

WOULD YOU FIND COUNSELING OR GROUP CLASSES ON SELECTED TOPICS HELPFUL?

Topic	Mothers' reactions				No. of mothers
	Very helpful	Somewhat helpful	Slightly helpful	Not needed	
Children's emotional needs	22	18	1	9	50
Child behavior	20	18	6	6	50
Care of children when ill	17	12	7	14	50
Children's growth and development	13	14	8	15	50
Nutrition	15	10	11	14	50

Conclusions

Many of the mothers I spoke to were most willing to openly discuss their feelings about motherhood. They made many different comments:

"To me there is nothing more rewarding. I feel that I have found my niche in life."

"This past year has been very difficult and unhappy for me. 'The terrible twos' describes it exactly."

"My main problem is that I do not have the confidence to feel that I am doing the right thing with the child. I never realized how difficult it would be to bring up a preschooler. I worry that my handling of her may cause her to have problems later in life."

"I'm really excited by the things he comes out with, things he says. It blows my mind."

"I often cry at night because I have been so miserable with them and resolve to do better the next day."

"There are times when she frustrates me no end and I have to walk out and leave her. Sometimes I'm afraid to start hitting her for fear I won't be able to stop."

"I think motherhood is the most important job in the world but not nearly well enough educated for or given enough support. We're trying to be superwomen. I don't handle it very well myself. I'm very impatient. You always should have empathy with the child and I don't always do it."

Many of the mothers in this study found their role as mothers very difficult and felt quite unprepared for it. Community health nurses could help these women with their problems if they kept in mind the mother's needs as well as those of the child.

I have outlined several recommendations which, based on my study, would serve to improve the quality of nursing service to mothers of preschool children. I recommend that all nurses:

- consider the developmental needs of all family members in each contact with the family of a preschool child;
- deliberately foster a closeness and friendliness with mothers to encourage them to discuss their concerns;
- take an active role in identifying mothers' concerns regarding their children's behavior and development rather than waiting for mothers to ask for advice.

I also recommend that community health nurses seek wider publicity for their services, especially home visiting and parent education groups. ➤

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L. Joan Brailey, the author of "Mothers Have Needs Too" based this article on research carried out for her master's thesis. Joan graduated with her M.Sc.N. from the University of Toronto in 1977 and has worked as a lecturer at that university since then. Her previous experience in community health nursing in Toronto includes two years with the Victorian Order of Nurses and eight years with the Borough of North York Department of Public Health.



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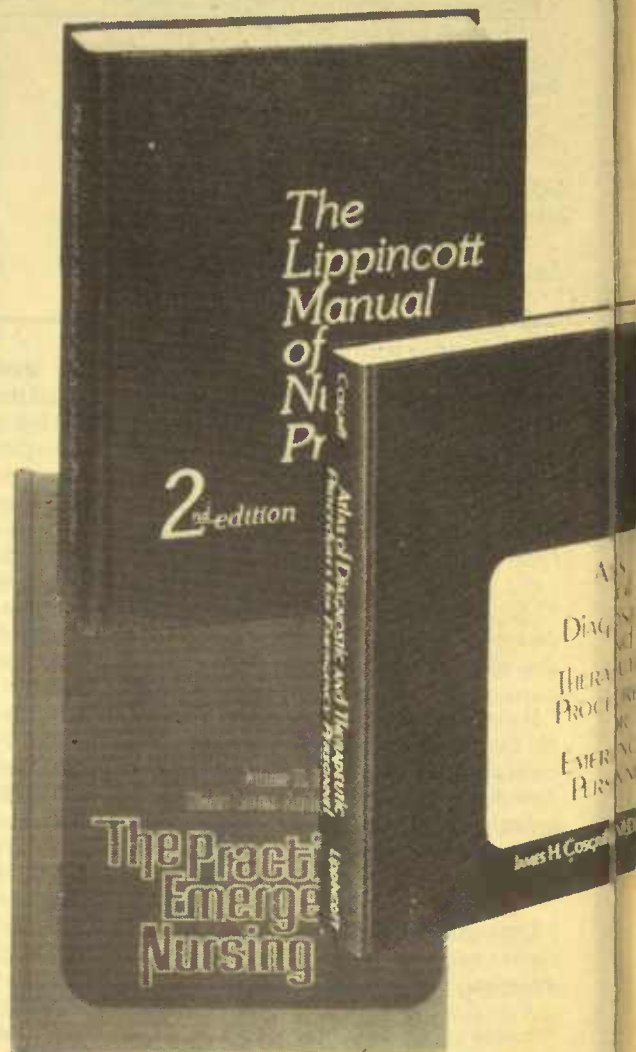
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A nursing approach to adult aphasia



"They talked as if I weren't there... they acted as if I didn't have any brains or feelings ... they often sounded as though I was as good as dead and then, of course, I wanted to be."¹

— A recovered aphasic patient

Shirley Christo

How do YOU react to the communication problem posed by the patient stricken by aphasia? Are you as confused and frustrated by his efforts to find the right words as he is? Do you think that because he doesn't respond, he doesn't know what is happening around him? Aphasia is not an uncommon malady and yet it remains somewhat of a mystery even for many nurses who have encountered it in their practice.

Imagine, if you can, being able to communicate only through a form of "charades", perhaps with the additional limitation imposed by restricted movements of certain body parts. Besides experiencing difficulties with elocution, there may be problems with reception. Taber's Medical Dictionary defines aphasia as:

*"inability to express oneself properly through speech or loss of verbal comprehension."*²

In the hospital setting, however, aphasia is not usually the patient's only problem. More frequently, it is "a common accompaniment to stroke and it is often the most disabling sequela."³ When this is the case there are major problems that both the nurse and patient must work together to overcome. Working with the aphasic patient, instead of against him, can in fact mean the difference between recovery and continuing affliction. Patients themselves have commented that "the attitude of the nursing staff concerning their improvement or ability to improve affected their morale tremendously."⁴

The following case study illustrates what can happen when a nurse applies what is already known about the communication process to establish contact with an aphasic stroke patient.

Seventy-two-year-old Michael Jones, a man who had always experienced reasonably good health, was rushed by ambulance to the emergency department of our local hospital after his wife found him unconscious early one evening in March, 1977. Shortly afterwards he regained consciousness. Upon examination, he was found to have had a stroke (CVA) with right-sided paralysis and aphasia.

After a further period of careful observation he was transferred to the geriatric ward, Room 412. On the morning of the third day, nurse Nancy C. was given Mr. Jones as part of her nursing assignment. After listening to an uneventful night report, Nancy collected her necessary linen and began to distribute it to her patients and prepare them for breakfast.

When she turned on the lights in Mr. Jones room, she greeted him brightly, as she had the other patients:

"Hello ... How are you? It looks as if we're going to have another nice spring day, don't you think? ... Can I help you prepare for breakfast now?"

Mr. Jones was visibly startled. He jumped and then let out a long stream of slightly garbled but intelligible swear words. At that point, Mr. Jones was not the only one who was startled. As Nancy set down her linen and approached the bedside, one thought kept running through her mind: "I thought they said he was aphasic."

She took Mr. Jones' hand and apologized for surprising him and asked again if she could help him get ready for breakfast. This time he looked back at her and simply nodded. After assisting him with mouth care, she raised him to a comfortable eating position. As Nancy assisted the other staff with passing out breakfast trays, her recent experience with the patient in Room 412 continued to baffle her. Why did he react as he had? One suggestion is that:

*"Sight is not infrequently affected by stroke ... An effect sometimes met with in these circumstances is a restriction of the field of vision so that the patient can only see centrally; ... In other cases, the visual field may have been laterally affected by the fact that he can only see with one eye or with one better than the other."*⁵

To avoid startling the patient, as Nancy startled Mr. Jones, the nurse should attempt to approach the patient within his field of vision. She might also consider repositioning the bed so that the doorway can be easily viewed.⁶

Looking directly at the patient when speaking to him and enunciating slowly and clearly can make the difference between the aphasic following or not following what is being said. Chattering, as one often finds oneself doing when greeting patients, creates definite problems for the aphasic. "He hears it as sound, but as speech it is confused and meaningless to him unless the speaker speaks slowly and carefully as she would to a deafened person."⁷ One patient has commented that everything sounded like a record being played at high speed.

Perhaps Mr. Jones was swearing because he had not seen Nancy enter, or possibly because he was aggravated by her rambling speech. More than likely, however, it was what happened to come out when he attempted to speak. Nancy's approach of simply ignoring it was the best solution. She remembered that:

*"Profanity may be repeated over and over often by the patient who can say little else and often he is powerless to stop saying it. This profanity should be ignored and explained to others if necessary as being an automatic kind of speech over which the patient has little or no control ..."*⁸

This particular trait is called perseveration and may involve any phrase or action.

Nancy's attention to the oral hygiene of her patient was particularly beneficial since good mouth care stimulates the oral cavity and facilitates tongue movement which is often impaired in the stroke patient. Indeed speech can never sound completely normal unless the dentures are properly placed and their absence can only increase the difficulty caused by the aphasic condition.^{9 10}

When Nancy returned to Room 412 to help Mr. Jones with his breakfast she was rather hesitant. She had cared for many stroke patients before but each one was so unique and she really felt that this time she had gotten off on the wrong foot. It was that very hesitancy which unknowingly saved her.

As she paused just after entering the room, Mr. Jones caught sight of her and vigorously beckoned her over to help him as he fumbled with his left hand to prevent the cover for his breakfast tray from clattering to the floor. Nancy ran to his side to catch the cover. She smiled at Mr. Jones and commented: "Whew ... that was close!" They both laughed aloud.

This one little incident seemed to go a long way towards putting both patient and nurse at ease and establishing that rapport which is so desired for a therapeutic relationship. It didn't work any miracles, however, and Mr. Jones was still completely baffled by his first attempt at feeding himself since his stroke.

Nancy laid things out for him on his tray and showed him where everything was, but he seemed unable to do anything but fumble around. Finally, in desperation, she picked up his spoon and showing it to him stated very plainly, "Here is your spoon." Then she placed it in his left hand and assisted him to direct it to the bowl. Surprisingly, Mr. Jones repeated the word very clearly and before finishing breakfast, he was also successful in saying "cup," "knife" and "glass" although he was unable to master "porridge" or "juice".

Nancy praised Mr. Jones considerably for his small successes in speech and reassured him that this was only the beginning. Then, having noticed his exhaustion from the effort of eating, she repositioned him comfortably and left him to rest as she moved on to her other patients' A.M. care.

In a very short period of time Nancy had stumbled on a number of significant factors affecting her future relationship with Mr. Jones. The ability to relax and, what is even more difficult, to make the patient relax, is particularly important. As one author notes:

*"The dysphasic patient is subject to tension from many angles ... we might say that he is bombarded with tensions ... one of the best possible ways of getting the patient relaxed mentally is by the very natural means of laughter."*¹¹

The simple little incident with the plate cover accomplished a release of tension for Mr. Jones and Nancy. For others it may take a good joke or even formal relaxation exercises. However, once achieved, it facilitates numerous things including word recall for the aphasic patient.¹²

As Nancy discovered quite by accident, allowing the patient to hold the object to be named also helps a great deal. The addition of the tactile sense to the possibly limited visual sense promotes much quicker response.¹³

Praise too, is of vital importance. The aphasic desperately needs this to continue his struggle to regain speech.

He also needs to be carefully watched for signs of fatigue. Studies indicate that weariness and emotional upset both decrease comprehension and speaking ability. When this happens it is important to stop what you are working on with the patient or to change to a less demanding task.¹⁴

By the time Nancy came back to Mr. Jones for his A.M. care, a fair bit of time had passed and it was approaching first lunch to which she had been assigned. Two of her colleagues realized this and came to help her out. At first, Mr. Jones appeared to be quite relaxed but, as the girls hurried around him doing his bath and changing his linen, he became increasingly agitated. They figured it was because he had not wanted to sit up in the chair so they fussed about him again trying to make him more comfortable. When they went off to lunch, they left him sitting in the chair with a magazine in his lap and the radio playing softly by his bedside.

Had they been more aware, the staff would have realized that it was not the

Figure one

HINTS FOR CARE OF THE APHASIC PATIENT

1. Speak *slowly* and articulate clearly.
2. Always allow the patient to see you face to face when you are speaking.
3. Give the patient frequent mouth care and put his dentures in to facilitate verbalization.
4. Numerous people and chattering tend to confuse the patient so avoid these situations whenever possible.
5. Give the patient plenty of time to respond and avoid showing signs of impatience.
6. Employ as many measures as possible to relax the patient and make him comfortable
7. If possible, place articles to be named in the patient's good hand to facilitate word retrieval.
8. Use words in context to aid the patient's recognition of them.
9. When the patient is to be left to rest, allow him to listen to the T.V. or radio. But ... be sure to turn the volume right down when you are conversing with him.
10. *Never* forget the fact that the patient can comprehend much more than he can verbalize.
11. Encourage the family to participate in care and treatment but guide them towards realistic goals for the individual patient.
12. Be prepared for the emotional outbursts which may occur and watch carefully for signs of frustration or depression which may precipitate them.
13. Relay any pertinent points about the patient to the speech pathologist.
14. Start assisting the patient with therapy — i.e. word recall as soon as possible.
15. When uncertain of what the patient is saying, give your interpretation back to him to be validated and avoid the possibility of misinterpretations.
16. When conversing with the patient, try to relate the topic to things that are of interest — i.e. family, friends, hobbies, or work.

chair at all that bothered Mr. Jones. When the nurses were all working together, they naturally conversed back and forth and this rush of voices and activity confused Mr. Jones as it would any aphasic.

Aphasics need time to digest what is being said before the next speaker begins and if there is any indication that the listener is in a rush, the patient's attempts to speed his response in co-operation only tend to delay it longer.¹⁵ Any additional interference by a radio or T.V. tend to further distract his attention and interfere with his comprehension.¹⁶ It is important therefore, that the nurse remember to turn the radio off when working with the patient and then to return it to normal listening level before leaving the room.

Many patients can receive considerable stimulation and assistance from the radio or T.V. during their solitary convalescent periods. Some speech pathologists even use music to facilitate the return of speech under a new treatment program called Melodic Intonation Therapy. They believe that music processed in the right hemisphere may aid the left hemisphere in word comprehension of a melodic nature.¹⁷

Mr. Jones had greatly enjoyed the music on the radio but he was pleased to have Nancy turn it off when she returned as the news had come on and it sounded very garbled indeed to him. When his lunch arrived, he tackled it with much enthusiasm and although the left hand created problems for him, he mastered it quite well.

Nancy sat with him as time allowed and took the opportunity to encourage Mr. Jones to recall various items on the tray. Just as they were finishing, Mrs. Jones arrived to visit. She was a very young-looking 70-year-old who could easily be assigned the role of loving grandmother. When her husband caught sight of her, he beckoned her over, obviously pleased to see her. Before she was even seated, however, Mr. Jones burst into tears accompanied by loud sobs.

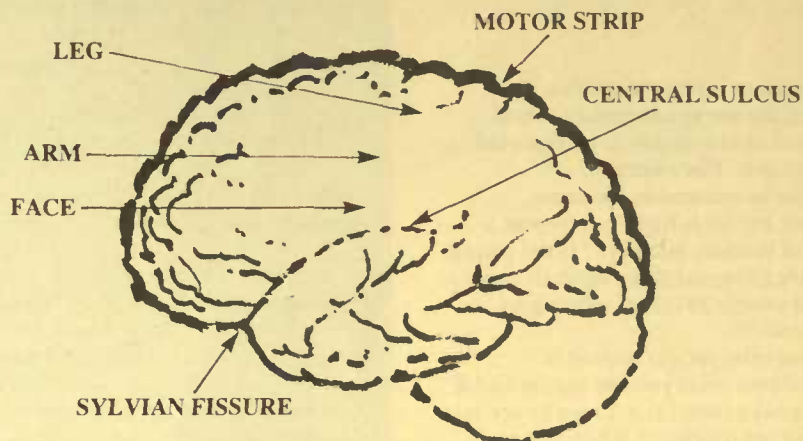
Nancy quickly retrieved a box of Kleenex from the windowsill and then politely excused herself and left, thinking that at this point the couple needed time alone.

Later, Mrs. Jones approached her at the nursing station, obviously quite distressed. She was worried about her husband's physical condition, but right now she was more concerned about his speech, his state of mind and his recovery capacity. Nancy felt very inadequate in her attempts to console Mrs. Jones but she promised to make an effort to get some information for her if she could.

At report, a detailed discussion of the care that they were giving Mr. Jones revealed that, when it came right down to it, the nurses felt they really knew very little about aphasia. With a little prodding from the head nurse, Nancy volunteered to conduct a team conference on the subject and to make up a card of nursing hints for the aphasic. (See figure one). The head nurse filed these cards, along with hints on other patient conditions pertaining to geriatrics, in a Kardex conveniently located so that anyone on the ward would have access to this information.

While reading the literature for her presentation, Nancy learned many things in addition to those already discussed. She read in one of the numerous articles on classification that the aphasic stroke patient with associated paralysis is likely to have a motor or Broca's aphasia. This is because the motor strip in the brain is very close to the motor speech cortex.¹⁸ (See figure two) If this is the case, the nurse should make a point of familiarizing herself with this particular aphasia. It is important to realize these patients often retain comprehension and can understand more than they are able to indicate.¹⁹⁻²⁰ Reports of interviews with post aphasics show that:

Figure two



1. *Fluent Aphasia* — Werniche's area in the posterior superior temporal gyrus.
2. *Non-Fluent Aphasia* — Broca's area in the posterior portion of the third frontal gyrus just anterior to the face region of the motor strip.
3. *Anomic Aphasia* — Angular gyrus at the tip of the superior temporal sulcus.
4. *Global Aphasia* — may involve one or more areas.

SOURCE: Watson R.T. "How to Examine the Patient with Aphasia" *Geriatrics* Vol. 30 (December, 1975) p.74.

*"Patients stated emphatically that their capacity to comprehend what was said in their presence returned much sooner than literature leads us to believe ... The capacity to understand returned very shortly after trauma and consistently increased long before they were able to respond."*²¹

For this reason nurses should understand that:

*"No one should speak in the presence of the patient as though he lacked hearing or intelligence or speak to him as though to a child regardless of how impaired he appears."*²²

They should also know that all aphasics experience a period during which there is some spontaneous recovery. It appears to be most noticeable for the first three months after onset.²³ Although all the authorities agree that therapy should be started as soon as possible, many patients are not well enough to cope with intensive speech therapy.²⁴⁻²⁵ If this is the case,

"Although a formal speech therapy program should not be initiated by the nurse she can, under the guidance of a qualified speech therapist co-operate in the patient's speech therapy program to

*reinforce and enhance language returning."*²⁶

In her conference, Nancy made it clear that this assistance with speech therapy was not something which would require additional time but rather it involved a more constructive use of conversation during time normally spent with the patient.

Helping with word retrieval is one area in which the nurse can easily give assistance. If a patient is having trouble naming an object, it can be placed in the good hand as already discussed. If he still has problems with the word (e.g. "cup") you might ask him to shut his eyes, relax and visualize the word in context. (i.e. "cup" as part of a place setting).

Usually, at this point, the patient will be able to pick out the word as you review with him what is being imagined.²⁷ If there is recognition with additional clues, it is important to realize that your patient may understand general ideas conveyed during short spans of conversation but not understand the specific information conveyed. Therefore,

*"Keep messages short and concise. Do not confuse him with unrelated verbal messages when you have specific information to give."*²⁸

If the patient is to go to speech therapy, the nurse can make several pertinent observations to be reported to the therapist. For example:

- Can he remember his name, address, etc. or is he able to repeat a series of random numbers? If the patient is unable to repeat three random digits, he'll be unable to follow a two-part command.²⁹
- Does the patient appear to comprehend what you are saying and if so, to what extent? (i.e. Does he seem to respond appropriately when you read him his menu or converse with him during nursing care?)
- Does he respond mostly with gestures and to yes and no type statements or does he attempt to verbalize?
- If he verbalizes does he pause or fumble for the right word or pronunciation of it or does he describe the item? He may even generalize using comments such as "thingamagig or Whatchamacallit." (See Figure three)

During the conference, Nancy stressed the fact that if the patient is attempting to speak, regardless of how primitively, repeated practice is essential.³⁰ However, because these people are adult and they have already learned speech before, you have to be very careful about not boring or discouraging them in any way.

One suggestion was to find out what the patient's interests are, i.e. family hobbies, etc. and to focus attempts at speech around these areas.³¹ They can also be utilized when testing and exercising the patient's reading and writing abilities. The immediate family are often very helpful here.

Mrs. Jones, for instance, was more than willing to supply the nursing staff with the family scrapbook and to bring in her husband's current magazines on sailing. She visited her husband faithfully twice a day and spent long periods of time attempting to converse with him and understand him. She did, however, have very definite needs of her own.

The shock, bewilderment, and anxiety which she experienced with the onset of her husband's illness were almost overwhelming. Not being familiar with the condition of her husband, she was equally unfamiliar with how to go about helping during his convalescence. As well, she had no idea to what degree her husband would recover. Nancy explained in her class that this is not uncommon:

*"The aphasic patient's communication efforts are not clearly understood by the patient's spouse. The spouse tends to view the aphasic's communication as less impaired than it actually is ... The positive bias on the part of the spouse might well provide some level of emotional support for the aphasic. On the other hand, this lack of understanding might also lead to ... unrealistic expectations ... and use of inappropriate amount and type of language while interacting with the aphasic."*³²

The nurse can co-operate with the speech pathologist and others to educate the spouse and family and help them to set realistic goals for recovery. Each patient is unique and, therefore, it is not easy to determine a prognosis. Treatment must not be too rigid or demanding and the family should most definitely be involved. No one is better able to relate former character traits and idiosyncracies of the patient and his speech than the spouse.³³

Both patient and family should be made aware of the progress that is occurring and the immediate goals that are being worked towards. They both need to be reassured, for instance, that frequent emotional outbursts are symptomatic of the condition, and that they will probably decrease in number as time passes. When they do occur, the best thing to do is probably to stand by until they are over and then if possible discuss why they might have occurred.

Figure three

WORD RETRIEVAL BEHAVIORS

Behavior	Example
Delay	Dr. Smith will give me a, just a minute now — (pass) tomorrow.
Semantic Association	I went to — not grammar school (high school) — there.
Phonetic Association	Vonnie, Monnie (Bonnie) gave me this.
Description	I mean a small joke, like twelve on one side and twelve on the other. (checkers)
Generalization	You get a free whatchamacallit deal (parking pass) if you buy something. (Seemed to represent a manipulative effort on the part of the patient to get ... the needed word).

SOURCE: Marshall, R.C. "Word Retrieval of Aphasic Adults" *Journal of Speech and Hearing Disorders* Vol. 41 (November, 1976) p. 451.

Usually, there is no apparent reason for them.³⁴ ... but there is always the possibility that they were the result of sheer frustration because of personal inability to do something or because someone has prevented the patient from achieving an attainable goal. The listener in a conversation may not have given the patient quite enough time to respond and interrupted just as he was going to speak.

If the people who are working with the patient take time to listen and help him work out any frustrations, they will probably notice a decrease in these outbursts of crying and/or violence.

Having gained considerably from Nancy's conference, the entire staff were able to approach Mr. Jones and his family in a much more confident and professional manner. Over the next few weeks, they experienced many very trying moments but, at the same time, they were able to recognize that Mr. Jones was definitely making progress.

He still experiences many difficulties with speech and writing and has limited use of his right side but he has been allowed to go home with his wife. Currently, he commutes twice a week to the speech therapist who reports that he appears to be making slow but steady progress. As an individual he appears to be much happier and to have regained considerable self-esteem. Somehow, this seems to be reward enough for the extra effort needed to work with the aphasic individual who depends upon the nurse to find out what can be done to correct his communication problem and to implement a remedy. ♡

CLASSIFICATION OF APHASIC PHENOMENA

Dr. A. Kertesz of St. Joseph's Hospital in London, Ontario, groups the numerous classification systems that have been devised for aphasia into four broad categories:

1. **MOTOR APHASIA** Primarily expressive aphasia or Broca's aphasia is an identifiable aphasic syndrome with hesitant, scant, and paraphasic, spontaneous speech, variably impaired repetition and naming, and relatively good comprehension. They read aloud poorly but reading comprehension is often good. Writing is affected similarly to speech.

2. **SENSORY APHASIA** as described by Wernicke ... 'is recognized by everyone even those wary of classifications' ... It features impaired comprehension and fluently articulated but paraphasic speech. Repetition naming or word finding difficulty and impaired reading and writing are always present.

3. **ANOMIC OR AMNESIC APHASIA** Probably the largest group of aphasics have relatively little expressive or receptive difficulty. Their speech is fluent at times very circumlocutory, occasionally paraphasic and shows obvious word finding difficulty ... They have near normal comprehension and repetition but their naming is impaired ... it can appear alone or may be the end result of recovering from other syndromes.

4. **GLOBAL APHASIA** Universally called because of the severity of involvement of both expressive and repetitive functions. The patient does not communicate and what is said is often a stereotypic repetitive utterance, at times an expletive without semantic value. At times these utterances are used quite fluently with inflection and associated emotional response. Comprehension seems almost entirely absent and even when one has the impression that the patient looks comprehending, the expressive outlets are so limited that it cannot be tested.

SOURCE: Kertesz, A. "Classification of Aphasic Phenomena," *The Canadian Journal of Neurological Sciences*, Vol. 3 (May 1976) p. 135-6.

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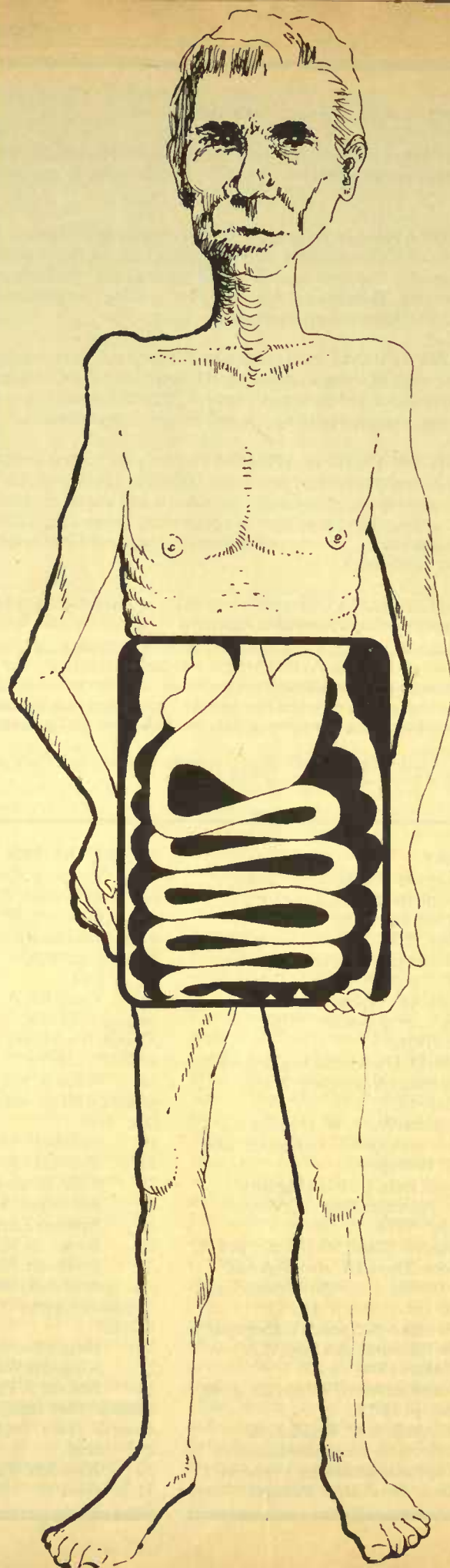
Crohn's disease: mourning the losses

Gloria Joachim

The losses that a person with Crohn's disease experiences are both physiological and psychological. Together, they make change inevitable, change in the way the patient sees himself and his body, in his dietary habits, in relationships and perhaps in his occupation.

Before the patient is able to accept these changes, he must come to grips with the loss of many things that are familiar to him. That means grieving, for it is through grieving that he will eventually be able to resolve his losses and adapt to change.

For the nurse caring for the individual with Crohn's disease, this has many implications. First of all, she must know what she is dealing with: that is, something about Crohn's disease and what it means to the patient. Secondly, she must be familiar with the grief process and associated nursing interventions, in order to help the patient work through some of his problems.



Roger

Roger is 27 years old. For the last ten years, he has had severe Crohn's disease of the small intestine and colon resulting in frequent hospitalizations for pain, diarrhea, fluid loss and fistulas. The disease has taken its toll; Roger is ten kg underweight and complains of feeling "constantly" tired.

After diagnosis, in spite of short remissions, Roger's disease got worse. It progressed to the point where he had diarrhea after ingestion of any food or fluid, as well as constant pain. As a result, he decreased his intake of food and arranged his life around places where toilets were readily available.

After completing high school, Roger worked as a parking lot attendant. As his symptoms progressed, he stopped working altogether, finding it too difficult to leave his station constantly to go to the toilet. As for the possibility of other work, Roger said he felt unprepared. For the past two and a half years, he has lived with his parents, on welfare and money that his parents give him.

Two years ago, Roger had an ileostomy because of the severity of his disease and resulting fluid loss. For about a year after surgery, he felt well, then his symptoms reappeared. This time, he was treated medically with Salazopyrine and a bland high-protein diet. In spite of treatments his pain and diarrhea worsened.

A month before I met him, Roger had had an ileotransverse colostomy in an attempt to overcome excessive fluid loss from the ileostomy. When I met him, he was on a bland high-protein high-calorie diet in small frequent feedings. In spite of a weight gain of one kilogram in the last week, he appeared gaunt and tired.

Roger's only medication was iron. Because of his previous ileostomy, he had developed the necessary skills to care for his stoma and he did so meticulously. His diarrhea seemed to be under control and he was scheduled for discharge within the next two weeks.

Personal experience had taught Roger a good deal about Crohn's disease. He was also aware of current modes of treatment, and was able to cite statistics about the disease. He had enough information.

In spite of the fact that his symptoms were under control and he would soon be discharged, Roger said he felt really depressed about his illness and about life in general. Physically, he felt fine. So my care centered on Roger's emotional needs, chiefly on his need to grieve.

Mourning the losses

Why did Roger need to grieve? Looking at his history, the number of losses that he had suffered over the last ten years was dramatic. Still, he refused to accept them, and was unable to incorporate the changes he had undergone into his life.

Because of its symptoms and the chronic progressive nature of the disease, every patient with Crohn's experiences certain losses. Loss of normal bowel and dietary habits are daily reminders of the disease. The patient may have to alter the way in which he thinks about his body, either because of weightloss or surgery or both. He may also lose his usual role in his family or his place in society. And all of these losses may constitute a real blow to his self-esteem.

In order to accept change, the person with Crohn's disease must mourn his losses. A nurse who is alert to the grief he is going through can provide valuable assistance to him, can help him to mourn.

A great deal has been written about those who mourn. It was Dr. Elisabeth Kubler-Ross who described the stages of mourning as predictable; grieving involves denial, anger, bargaining, depression and acceptance. Let's take a look at how these stages apply to the grief work of a patient with Crohn's disease.

In the *denial* stage, the patient with Crohn's disease attempts to defend himself against the reality of his losses. He may maintain that there is nothing wrong with him, consume roughage and spicy food, attribute abdominal cramps to the flu, refuse diagnostic tests, or ignore the symptoms of fluid loss. Unless the nurse is aware that the patient is beginning to grieve, these actions will appear childish or irresponsible. What the nurse can do, is to allow the patient time to deny his illness until he is ready to be aware of the reality of his losses. With patience, understanding and support, the patient will be able to move on in his grief work.

Anger is a natural consequence of loss; the patient with Crohn's disease may feel rage that *he* is the one enduring all those losses. This anger may be triggered suddenly, for example when he sees a healthy nurse, friend or family member. It may show itself in a number of ways: throwing food or objects, outbursts of temper, exaggerated complaints of pain, or "accidents" on the way to the bathroom. Tolerating expressions of anger is often very difficult, especially for the person on the receiving end, but it is important for the nurse to let the patient know that he is acceptable. Acknowledging the patient's anger and empathizing with him are ways to help him accept the way he feels.

→ The *bargaining* phase of grieving marks the beginning of the individual's acknowledgment of his losses. It is the patient's attempt to delay or dodge painful feelings; he tries to bargain for more time to accept his losses. For example, the patient requiring surgery might promise himself or God that he will be a better person or a harder worker if only his fistula will heal.

This is an example of internalized bargaining; there are also attempts to bargain with others. For example, the patient may attempt to bargain for a weekend pass by promising doctors and nurses that he won't cheat on his diet. A nurse who recognizes this bargaining as part of the grieving process will be able to understand her patient better. Because of this understanding, she will be able to support him by reminding him of the reality of his illness while at the same time, allowing him to maintain hope. When bargaining lessens, feelings of *depression* and great loss take over. The patient begins to realize fully the implications of his disease, to realize that his view of himself must change. This realization brings great sadness. Every adjustment may seem insurmountable: changes in diet, the need to be aware of the location of toilets, pain and cramping, or wearing an appliance may seem unbearable to the patient.

The nurse can help by encouraging the patient to give words to the way he feels, and by accepting his tears. If religious faith is an important dimension in his life, a visit from his clergyman or the hospital chaplain might be helpful. Teaching the patient factual information about Crohn's disease and about the changes he will eventually be able to make can be helpful in increasing his confidence and decreasing his anxiety about the unknown.

Acceptance of Crohn's disease and all that it means is difficult. It can only occur after the patient has worked through his feelings and is able to incorporate his losses into a new image of himself. At this point, he should be able to discuss his needs knowledgeably and to adhere to his treatment program willingly. If surgery has been necessary and a stoma is present, he should be able to care for it and change his appliance. He will be aware of the chronicity of Crohn's disease, but will be able to see a hopeful future for himself.

Crohn's disease

The real cause of Crohn's disease remains unknown. It has been suggested that the process is an allergic response, or that the disease is one manifestation of psychological stress.

Whatever the cause, Crohn's disease is being seen with increasing frequency. Perhaps greater life stresses or better diagnostic tools could account for this apparent rise in incidence. The disease is usually diagnosed in individuals between 20 and 40 years of age with a higher incidence occurring in Jewish people.

What is it?

Crohn's disease, also called regional enteritis, is a slowly progressive inflammatory process that most commonly affects the small bowel. The process results in ulcerations that involve all layers of the intestinal submucosa.

Looking at the diseased bowel gives us a dramatic picture of what Crohn's disease is about. The affected areas of the bowel look thick and congested next to areas of normal bowel: there are ulcerations and cracks around inflamed areas, giving the mucosa a characteristic "cobblestone" appearance. Later stages of the disease will be marked by narrowing and fibrosis of the lumen of the bowel.

Complications resulting from Crohn's disease include strictures of the bowel and fistulas (abnormal connections between two organs) developing for example between the bowel and bladder or bowel and vagina. Fistulas occur very frequently and may result in peritonitis.

The patient with Crohn's disease will experience remissions and exacerbations throughout his illness. Symptoms will depend specifically on the area of the bowel involved and its extent, and the stage of development of the disease.

Initially, Crohn's disease develops insidiously, with such signs as borborygmus (audible bowel sounds), flatulence, mild cramping, and some diarrhea. Symptoms may also occur suddenly, most often following stress. A diagnosis of Crohn's disease is commonly made after months or even years of vague gastrointestinal complaints. Symptoms may be precipitated by stress, trauma, fatigue, and foods such as milk products, fatty dishes, roughage and fruits.

Most patients with Crohn's disease experience an intermittent peristaltic type of pain. Crampy abdominal pains may follow eating because of the patient's narrowed intestinal wall. Many patients mistakenly limit their intake in order to avoid this pain, a strategy that may result in malnutrition.

Pain may vary from a slight discomfort or a bloated feeling to severe and colicky pain. If the patient has involvement in the terminal ileum, he may feel a constant aching pain because of irritation of somatic nerve endings in the peritoneum. At times, severe pain may mimic appendicitis, so that a careful diagnosis must be made to determine the cause of the pain.

Most patients have some form of diarrhea. The extent and site of the disease has an effect on the frequency of diarrhea; many patients are awakened during the night because of it.

Fever is often a sign that fistulas or abscesses are present. Nausea and vomiting may occur if Crohn's disease involves the stomach and duodenum; but it may occur if a partial bowel obstruction exists in the case of a diseased bowel.

Many patients with Crohn's disease lose weight and are weak because of anorexia, malaise, a limited intake (in order to control symptoms) and a reduction in the absorptive surface of the gastrointestinal tract either because of the disease process itself, or resulting from surgery. Because of constant diarrhea, calcium, potassium, magnesium and sodium chloride deficiencies may occur.

Diagnosis

Crohn's disease is diagnosed on physical examination and through the use of specific diagnostic tests. A hard mass, representing the thickening and narrowing of the terminal ileum, may be palpated in the right lower quadrant of the abdomen. Weight loss, pallor and other signs of poor nutrition contribute to a diagnosis of Crohn's disease. Barium enemas permit visualization of the GI tract and the lesions present; and sigmoidoscopy reveals the characteristic cobblestone mucosa. Stool examination may show occult blood. A D-xylose test may reveal only small amounts of D-xylose in the urine because of a decreased absorptive capacity of the small intestine.

Treatment

Diet

Patients with Crohn's disease are placed on high protein bland diets. The aim of diet therapy is to provide adequate nutrition while controlling pain and diarrhea. Milk products, roughage, alcohol, coffee and iced drinks are omitted from the diet. If flatulence is a problem, fatty foods are also excluded.

For patients who are underweight, Sustagen and Flexical are taken between meals to increase the caloric intake. Hyperalimentation is being used more frequently to correct nutritional deficiencies in patients with severe Crohn's disease, because it ensures adequate caloric intake while allowing the bowel to rest and heal. Because of frequent anemia, foods high in iron as well as iron supplements are encouraged. Attempts must be made to improve fluid and electrolyte imbalances.

Drugs

Drug therapy is aimed at the control of pain and diarrhea:

- anticholinergics like Donnatal may be taken prior to meals to assist in the control of diarrhea. Psyllium muciloids such as Metamucil decrease the fluid content of the stools, thereby decreasing diarrhea and perianal irritation
- minor tranquilizers may be used to relieve anxiety during acute exacerbations of the disease
- antibiotics are prescribed only in the presence of acute infections because they may suppress normal flora and cause even more diarrhea
- anti-inflammatory drugs, such as Salazopyrine, are used, but seem to be less successful in treating Crohn's disease than in the treatment of ulcerative colitis
- steroids, especially ACTH, may reduce fever and diarrhea, increase the patient's appetite and help the patient to feel healthier. However, the side effects of steroids, such as intestinal perforation, Cushing's syndrome, hemorrhage and psychosis, make their administration a choice only when all other medical measures have failed.

Surgery

Surgery is performed on patients who are not responsive to medical treatment or who have complications such as intestinal obstructions. The diseased area of the bowel is surgically resected and remaining portions of the bowel anastomosed together. Other procedures include ileotransverse colostomy, an ileoascending colostomy or total colectomy with an ileostomy. When a stoma is the result of surgery, the patient needs all the nursing support given to any ostomy patient. Surgery does bring immediate relief of symptoms; however there is a high rate of recurrence of symptoms around the resected area.

Accepting the changes

Roger really needed the opportunity to express the way he felt about his losses. Our conversations together made it evident to me that he had not accepted many of the changes that his disease had demanded of his life; and he appeared to be very depressed.

Here was a man who had had two ostomy procedures. He had lost important relationships in his life — most of his old friends had married and he had not maintained contact with them. Nor had he established any meaningful relationships in the past two years. He had given up his job and felt dependent on his parents because he couldn't see any way out of his present situation. He had lost any sense of self-esteem. In addition to these losses, he lived with a very vivid fear that his disease would flare up again.

I knew that he had to acknowledge the importance of these losses in order to accept the changes. I was uncertain about how successfully he had mourned and began to work with him to come to grips with his losses and grieve.

When I encouraged him to express the way he felt, what emerged was anger. He raged about giving up his job, having to live with his parents, and losing his friends. He said he felt so helpless, and that this feeling made him "hate" those people around him who were healthy. He spoke loudly and bitterly. At the same time, he said that he was comforted that I accepted these feelings.

Later in the course of our visits, there came a day when Roger stopped railing against what had happened to him and began to cry and express deep sadness. He then talked about his worry about not having a job, his shame when he looked at the scars on his body, his confusion about his sexuality. He also talked about his embarrassment when gas escaped from his colostomy, or when he had to 'excuse' himself in certain social situations. He talked about these concerns repeatedly, as if expressing them over and over again helped him to accept their reality.

Roger needed time to really experience his own sadness. But after time, he was ready for change. So we began to work together to make realistic plans for the future, realistic because they were plans that took his losses into account. We began to meet on a weekly basis to plan long- and short-term goals that seemed reasonable to both of us.

Roger told me that he wanted to have a girlfriend and eventually to be married. This was one long-term goal that we explored. We also discussed other goals — finding a style of life compatible with his Crohn's disease and his needs and choosing a career that was suitable to him.

The short-term goals we established were immediately accessible. We decided that he should take steps towards forming a friendship in the next few months. Other goals included finding a job that he could begin as soon as he was discharged, and finding an apartment within two months so that he could gain more independence from his parents. Together we planned the ways in which he could meet these goals. Roger expressed the way he felt about each of these plans and talked to me about the alternatives. We listed the steps he could take in achieving some of his goals.

For example, Roger took positive steps towards finding a job that he could begin as soon as he was discharged from the hospital. First he made a list of the jobs that he was qualified for, considering his physical health, his strength and his interests. Then he narrowed these choices, checked the classified ads of the local paper and applied for work. On a day pass, Roger was hired as an optician's assistant.

Crohn's disease is a chronic illness that requires constant supervision and adaptations. When I met Roger, he had had the disease for ten years; for almost three years, he had been completely dependent on his parents. By working through the sadness that he felt over the things that had happened to him, he was able to accept his losses and to adapt to change. He was ready for beginnings. Getting a job and looking for an apartment were small beginnings. ☛

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DIGITALIS:

Antiarrhythmic and toxic effects

Pam Haslam

Digitalis is one of the oldest and most effective drugs used in the treatment of congestive heart failure. It is also being used as an antiarrhythmic agent to treat such arrhythmias as atrial fibrillation and atrial flutter. In spite of its wide success however, digitalis administration is not without its problems. Toxicity is common, and can be the cause of fatal arrhythmias.

As nurses, we have a responsibility to know as much as we can about drugs in the digitalis family, their action, and the signs and treatment of toxicity.

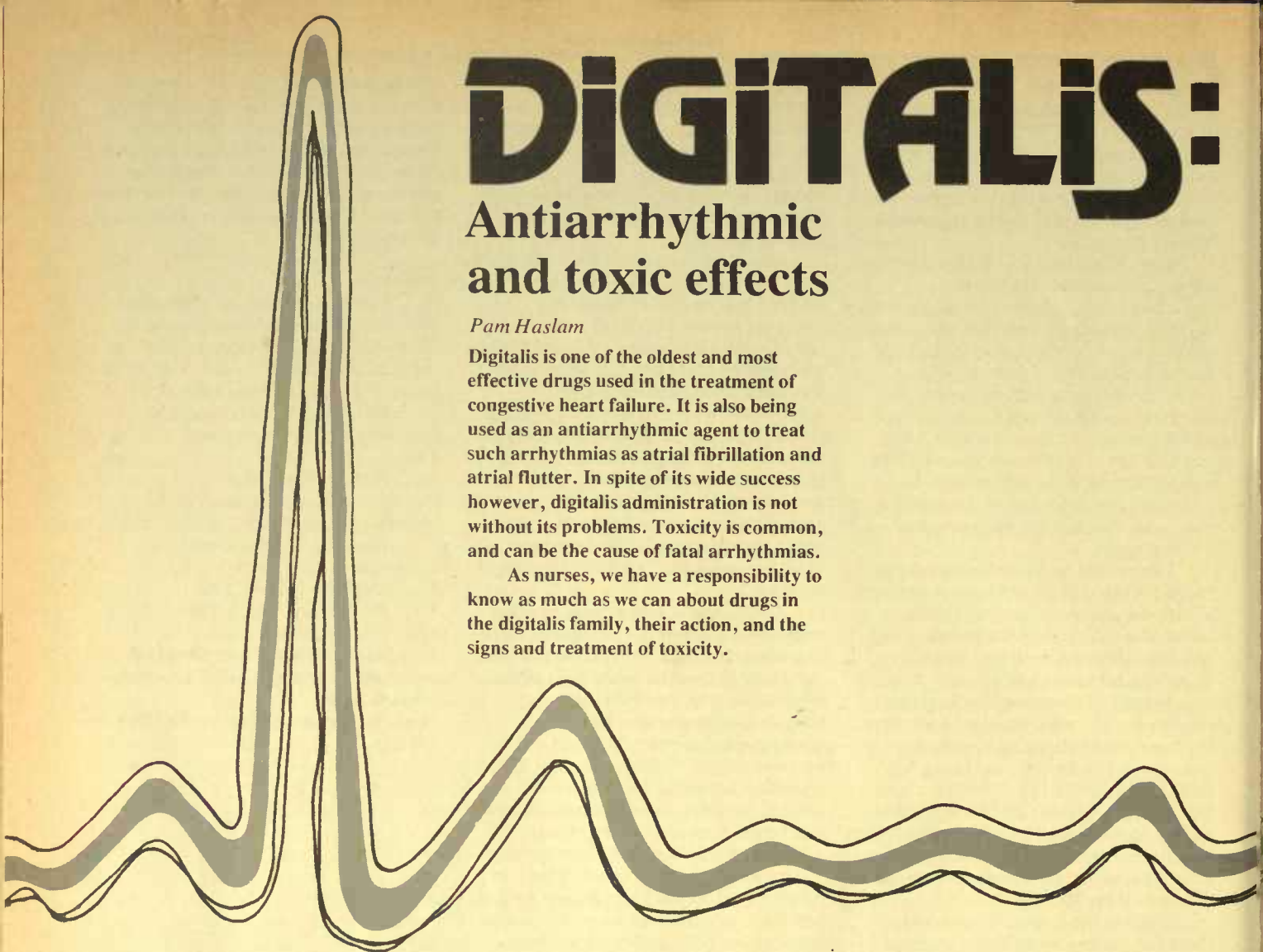
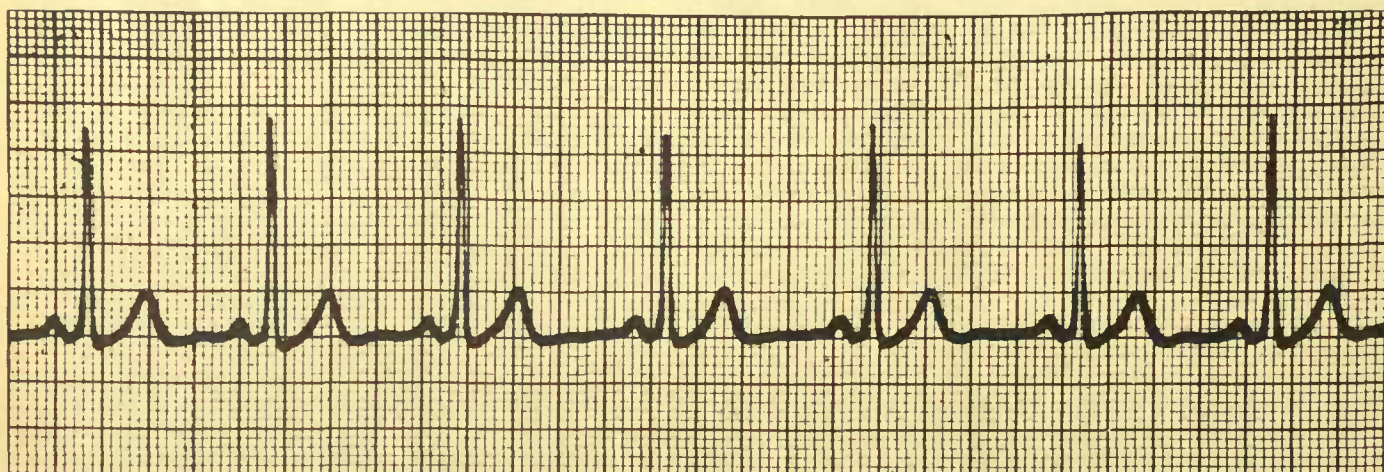


Figure 1



Normal sinus rhythm

The cellular effects of digitalis

First of all, let's take a look at the way in which digitalis affects the heart muscle. The drug has three main modes of action including an inotropic effect, a vagotonic effect and specific electrical effects on myocardial cells. What do these effects mean at the cellular level?

Digitalis is perhaps best known for

its positive inotropic effect; in other words, it increases the contractility of myocardial muscle. It is suspected that this is accomplished by direct action on the cell membrane and a subsequent increase in the flow of calcium ions into the cell. Within the cell, calcium acts as a catalyst to increase the strength of myofibril contraction.

Digitalis drugs also have a strong **vagotonic effect**, increasing vagus nerve action at the sinus node and particularly at the atrio-ventricular (A-V) node. Since any vagal activity acts to slow impulse formation in the sinus node and delay impulse conduction through the A-V node, an increased vagal stimulus will reduce the heart rate and prolong conduction even further.

This action also has a positive inotropic effect. As the heart rate slows, the diastolic period is prolonged, allowing more time for the heart chambers to fill with blood. The increased blood volume stretches the myocardial muscle and results in a firm myocardial contraction. To a certain extent, the more stretch applied to a myofibril, the firmer the subsequent contraction will be.

The third mode of action of digitalis drugs can best be described in terms of their **electrical effects**. Digitalis acts directly on the myocardial muscle, altering the electrical properties across the cell wall.

For years, it has been known that the interior of any muscle cell has a negative charge with respect to the exterior. If tiny microelectrodes are placed on each side of the myocardial cell wall, a potential difference of approximately 90 millivolts (mV) can be measured, the interior of the cell being negative in relation to the exterior.

difference in charge across the cell wall increases.

This difference in potential is measured in electrical units called volts. Since the potential across body cell membranes is weak, it is expressed in terms of millivolts ($1\text{mV} = 1/1000 \text{ volt}$).

If the potential difference across a myocardial cell wall is -120 mV (a higher negative voltage than its normal -90 mV), the cell may be more difficult to stimulate, but once stimulated, a strong current flow will result. On the other hand, if the potential difference across the myocardial cell is less than -90 mV (e.g. -80 mV) the cell may be easier to stimulate. The resultant current flow however, will be weak.

This receptiveness to outside stimuli or ease with which the cell can be stimulated is termed *excitability*. A cell with a high excitability is easy to stimulate; a cell with a low excitability is more difficult to stimulate.

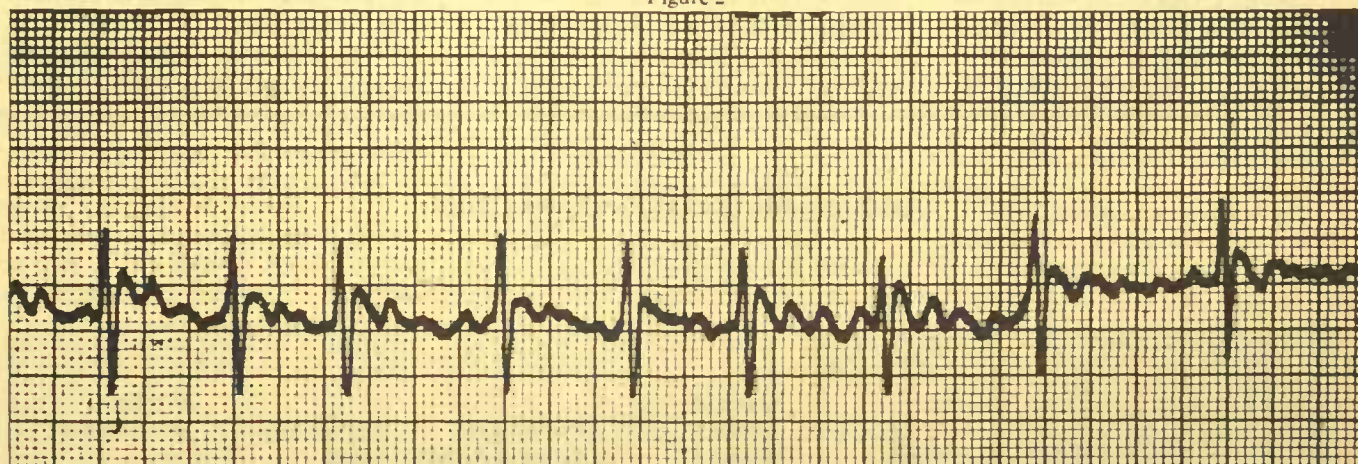
When digitalis preparations make contact with the cell membrane, they interfere with the enzyme carrier systems responsible for maintaining a difference in potential across that membrane. Positively charged ions are allowed to make their way into the cell, ultimately decreasing the voltage across the cell membrane to a less negative value (i.e. from -90 mV to -80 mV). This reduction in voltage will do two things: it will increase the excitability of the cell

treatment of patients with congestive heart failure to increase the strength of myocardial contractions. More recently however, it has also proven useful in the treatment of supraventricular arrhythmias (i.e. arrhythmias originating above the ventricles) such as atrial fibrillation and atrial flutter. Digitalis is used to treat atrial arrhythmias because of its ability to slow conduction at the A-V node. This action protects the ventricles from any electrical chaos occurring in the atria.

Consider the patient with *atrial fibrillation* (Figure 2). This arrhythmia is characterized by an incredibly rapid and irregular rate, as thousands of irritated atrial cells fire individually or in groups. In fact, rates characteristic of atrial fibrillation are usually too rapid to be discernible on electrocardiograms (ECG). The prime danger inherent in this type of pathology is that many of these atrial cellular currents can be conducted on to the ventricles. This would cause the ventricles to contract so rapidly that they would not have time to fill with blood. Total cardiac output would drop to zero.

Because digitalis reduces conduction speed through the A-V node, it prevents the rapid passage of these atrial impulses to the ventricles. This in turn will slow the rate of ventricular stimulation. In the treatment of atrial fibrillation, digitalis is given in recurrent

Figure 2



Atrial fibrillation

The presence of this potential difference between either side of the cell wall is the condition necessary for the initiation of an electrical current — the greater the potential difference across the cell wall, the greater the flow of current once the cell has been stimulated. Since all myocardial cells have a uniform resistance, the current flow has the potential to increase as the

and reduce the conduction velocity.

The clinical response to digitalis, therefore, is based on its inotropic and vagotonic effects, as well as its ability to increase the excitability of the myocardial cell.

Digitalis—an antiarrhythmic

Digitalis is used in clinical practice for two major reasons. First, it is used in the

doses until A-V conduction is impaired to a degree that slows the ventricular response to 60-80/min at rest or 100 per minute if the patient is undergoing moderate exercise. At this point, a maintenance dose is given to sustain the desirable ventricular rate.

Occasionally, a patient with atrial fibrillation will revert to a normal sinus rhythm when he is placed on digitalis.

Figure 3



Atrial flutter

This is not a direct result of the action of digitalis, but occurs as a side effect. It seems that as the inotropic action of digitalis restores cardiovascular function to normal, increased coronary perfusion and myocardial oxygenation alleviate the irritation that initiated the fibrillation.

Atrial flutter (Figure 3) may also be treated with digitalis. Atrial flutter is a rapid rate atrial arrhythmia believed to originate in a localized site of the atrial wall. Flutter waves occur regularly at a rate of 250 to 350 beats per minute on electrocardiogram. Conduction of these waves is frequently blocked at the A-V node.

What may appear on the cardiogram is a situation wherein every third, fourth or fifth atrial stimulation wave traverses the A-V node and excites the ventricles. In other words, the conduction ratio could be 3 to 1, 4 to 1, or 5 to 1. The

major hazard of this arrhythmia again lies in its potential — there may be sudden changes in ventricular rates as conduction through the A-V node alters.

For example, a patient with atrial flutter may have a conduction ratio of 6 to 1 with a ventricular rate of 50/minute. This means that only one out of every six atrial stimulation waves is being conducted through to the ventricles. If conduction across the A-V node alters, permitting conduction of every atrial stimulation wave, the resulting 1 to 1 conduction would initiate a ventricular rate of 300/minute.

Digitalis therapy can be useful in the treatment of atrial flutter, particularly when appropriate degrees of block can be achieved to attain a normal ventricular rate. The drug's ability to inhibit conduction across the A-V node will help to protect the ventricles from

rapid rate atrial stimulation. As in the treatment of atrial fibrillation, digitalis therapy aims at reducing ventricular rates to 60 to 80/minute at rest or 100/minute with moderate exercise.

Any digitalis preparation can be used in the treatment of these arrhythmias. The aim of therapy is to administer substantial initial doses of digitalis in an attempt to lower the ventricular rate to an acceptable level, a process called digitalization.

Digitalization can be achieved at a rapid, moderate or slow rate depending upon the drug used and route of administration chosen. Preparations such as Ouabain and Digoxin begin to act within minutes. On the other hand, digitalis leaf and Digitoxin, do not have such a rapid onset.

The patient's condition will dictate the type of preparation and the route

Table 1

COMMON DIGITALIS PREPARATIONS

Drug	Trade Name	Route	Onset of Action (Min.)	Duration of Effective Action	Therapeutic Dosages	
					Digitalization Range	Average Maintenance Dose
Digitalis Leaf	Digifortis Digiglusin Digitora	Oral	25-120	2-3 days	1.0-2.0 g	0.15 g
Digitoxin	Crystodigin Digitaline	Oral, I.M. or I.V.	25-120	2-3 days	1.0-2.0 mg	0.15 mg
Digoxin	Lanoxin Davoxin	Oral, I.M. or I.V.	5-30	8-10 hours	1.0-4.0 mg	0.25-0.5 mg
Lanatoside-C	Cedilanid	Oral	10-30	16-36 hours	5.0-10.0 mg	1.0 mg
Ouabain	G-Strophanthin	I.V.	3-10	9-12 hours	0.5-1.0 mg	N/A

used. The intravenous route guarantees the most rapid action, but it is used for emergency purposes only. Intramuscular injections of certain types of digitalis also produce a rapid onset of action, but injections are known to be painful. The oral route of administration is preferred whenever it is possible.

Table 1 lists common types of digitalis, their recommended dosages, onset of action and route of administration. In order to understand the clinical and toxic effects of these drugs, it helps to be familiar with the action of at least one of the digitalis preparations.

toxicity can cause fatal arrhythmias. It is for this reason that early recognition of toxicity is of paramount importance.

Arrhythmias

As a general rule, almost any type of arrhythmia can be caused by digitalis excess. But some arrhythmias occur more frequently than others. For example, frequent *premature ventricular contractions* (PVC's) are common. These result from the increased excitability of myocardial cells, particularly the Purkinje fibers (potential pacemaker cells which are scattered throughout the ventricles).

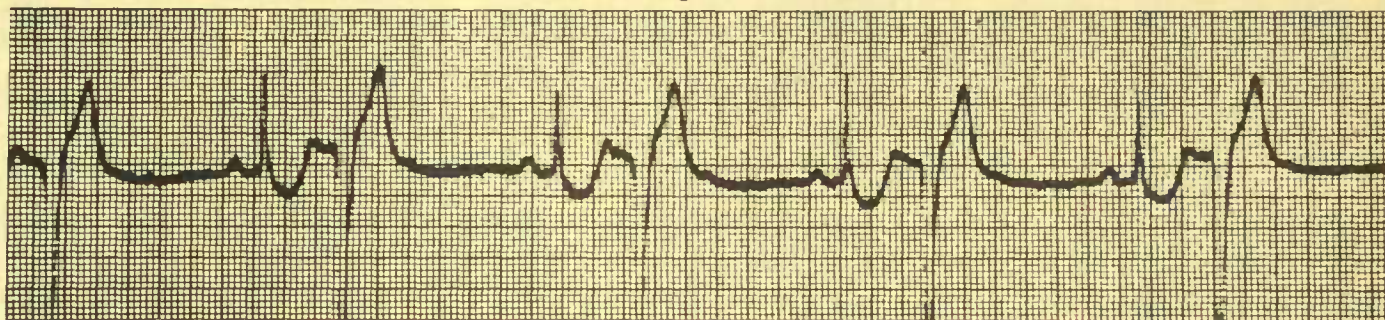
In digitalis toxicity, a normally conducted beat may frequently occur

block is so commonly associated with digitalis excess that it is always considered a digitoxic arrhythmia until proven otherwise.

All three of these arrhythmias have properties in common. They involve increased excitability of atrial cells and conduction block as rapid rate atrial stimuli attempt to penetrate the A-V node and reach the ventricles. It is ironic that some of the arrhythmias that are treated by digitalis may develop independently as a toxic effect of the same drug.

Heart block is another disorder of conduction resulting from digitalis overdose. In many cases of digitalis

Figure 4



Digitoxic arrhythmias — ventricular bigeminy

Toxicity

Digitalis toxicity stands out as the greatest problem involved with its administration. One large scale study¹ reports signs of digitalis intoxication in 23% of hospitalized patients taking the drug. Digitalis is one of the most frequently prescribed drugs, and some clinicians feel that toxicity has reached almost epidemic proportions.

Part of the problem lies in the fact that although digitalis is widely used in the treatment of heart failure and certain arrhythmias, it also has a low safety margin. The difference between therapeutic and toxic blood levels for this drug is very narrow. Digitalis

paired with a PVC. In other words, you may see a normal beat, followed by a PVC, followed by another normal beat, which in turn, is followed by a PVC. This is called *ventricular bigeminy* (Figure 4).

The sudden appearance of PVC's occurring sporadically or in bigeminy in a patient who has recently been digitalized should alert the nurse to the possibility of digitalis toxicity. This arrhythmia is of particular importance since it may suddenly deteriorate into ventricular tachycardia or the fatal ventricular fibrillation.

Other arrhythmias caused by digitalis toxicity are *atrial flutter*, *atrial fibrillation* and *paroxysmal atrial tachycardia (PAT) with block*. PAT with

toxicity, a normal sinus impulse will not be conducted through the A-V node, or if conducted, its passage will be exceedingly slow.

Heart block is classified according to the degree of its severity. In a first degree heart block (Figure 5), impulse passage through the A-V node is retarded; in second degree heart block, some sinus or atrial impulses will be unable to penetrate the A-V node. In third degree heart block, all sinus or atrial impulses are blocked at the A-V node — the atria and ventricles beat independently.

Heart block may be detected through examination of the the P-R intervals on the patient's ECG. This

Figure 5



Digitoxic arrhythmias — first degree heart block

interval is measured from the beginning of the P wave to the beginning of the Q-R-S complex, and represents the time required for the impulse generated in the sinus node to reach the ventricles. It should not take any longer than 0.2 seconds for this process to be completed. If a patient on digitalis therapy begins to show prolonged P-R intervals on his ECG, you can suspect conduction delay in the A-V node and should report your observations immediately.

The relationship between potassium and digitalis requires special scrutiny. The myocardial effects of digitalis are the result of its ability to inhibit the sodium potassium pump in the cell wall. The sodium potassium pump is the enzyme carrier system responsible for maintaining the difference in electrical potential across the cell membrane.

Digitalis exerts its effects by binding on specific pump sites. The binding of digitalis with the myocardium is extremely sensitive to changes in potassium concentration. Potassium ions compete with digitalis for at least some of the binding sites on the cell membrane. If a patient's serum potassium values are low, more binding sites will be available on the cell to combine with digitalis. This will increase the cellular effectiveness of the drug and allow digitalis intoxication to occur at a usually normal dose.

For this reason it is extremely important to avoid a low potassium state in patients receiving digitalis preparations. Potassium supplements are often recommended for patients who are taking potassium-depleting diuretics as well as digitalis.

The unmonitored patient

If your patient is not being monitored by ECG, it is still possible to assess his response to digitalis. Close attention should be paid to the rate as well as the rhythm of the patient's pulse. You may detect slow pulse rates, a result of the vagotonic effects of digitalis. Many patients are cautioned to omit their daily dose if their pulse rate falls below 60 beats a minute (or below 90 to 100 beats per minute in children).

Digitalis toxicity occurs frequently. It is very important to detect it. Take the patient's pulse for a full minute before administering the drug. Pay attention to the quality of the pulse as well as to the rate. Many digitalis-induced arrhythmias such as atrial fibrillation, will cause pulse rates to become irregular.

Measurement of the apical-radial pulse is very useful. If the apical rate is more rapid than the radial pulse rate, it means that the stroke volume is not always sufficient to be detected peripherally. This pulse deficit is frequently found in patients with atrial fibrillation or atrial flutter with varying A-V conduction. Other digitoxic

arrhythmias such as PVC's, occurring singly or in bigeminy, will also cause irregularities in pulse rates and pulse volume.

Digitalis toxicity can produce systemic effects as well as arrhythmias and conduction disturbances. The earliest signs in fact, may be extracardiac in nature. The most common of these include anorexia, nausea, vomiting and diarrhea. Neurological side effects have also been reported — mental depression, personality changes and abnormal visual sensations such as color vision in yellow, green and brown, are not uncommon.

Treatment

The treatment of digitalis excess depends upon the severity of the toxic manifestations. When signs of digitalis toxicity become apparent, it is most important to discontinue the drug. If, at this point, the patient's clinical status is good, and if the patient is tolerating the arrhythmia well — by maintaining an effective cardiac output — no other therapy is required. If cardiac output falters as a result of digitalis intoxication, hypokalemia is investigated and corrected with potassium infusions.

If the patient has developed a severe rapid rate arrhythmia such as PVC's, ventricular tachycardia or rapid atrial fibrillation, suppressant therapy with Lidocaine, Inderol or Dilantin may be initiated. These drugs are administered very carefully, since they also depress myocardial contractility and may potentiate further heart failure.

If, on the other hand, digitalis toxicity has resulted in an exceedingly slow heart rate, such as an A-V block or other bradycardias, the patient is usually treated with Dilantin. This drug stabilizes the myocardial cell by increasing the voltage across the cell membrane. Once stimulated, conduction in these cells will increase. By this means, Dilantin will accelerate A-V conduction, and at the same time, suppress ventricular excitability. Temporary pacing is considered as an alternate means of treating bradycardias and A-V blocks.

Although there is a narrow safety margin, the therapeutic effects of digitalis far outweigh the potential problems of toxicity. But since toxicity can cause fatal arrhythmias, any nurse giving the drug should be on the alert for early signs of intoxication. This means understanding the action of the drug and being familiar with at least one of the many digitalis preparations. Every nurse has given digitalis at some point during her career — understanding the drug fully is an important nursing responsibility. ❖

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Audiovisual

A Child Life Program

Leigh Beauchamp

It is obvious that much more work must be done to lessen the traumatic effects of hospitalization on children. While those who work in hospitals are generally aware of these effects, many do not know how to lessen them. They may also be restricted in their efforts by shrinking budgets and increasing workloads.

The Children's Hospital of Eastern Ontario has set out to share their experiences in confronting these problems with professionals, parents and children in a recently-completed half-hour

visit of a local ballet company and scenes from a birthday party.



Ottawa Cablevision provided the equipment and technical expertise for the production. The Community Relations Section and Child Life Department of Children's Hospital of Eastern Ontario had complete control over the film's final content and editing, an advantage that would not have been possible with a commercial station. This formula appeared to work well for all concerned. Another bonus was the flexibility of Cablevision ... more than thirty hours of taping went into the program, and this was arranged to coincide with patient schedules and special events.

A small video camera was used throughout which meant that the hospital was not inconvenienced by camera crews or large television cables.

The hospital had more than one project in mind when it began the documentary. It was designed to be included in a six-part presentation to the International Conference for the Association for the Care of Children in Hospitals, held in Washington D.C. in June. This conference gave hospital

representatives time to share their ideas and concerns about the care of children with professionals from other countries.

The program has already been televised on local cable stations throughout the Ottawa area. In communities with no cablevision facilities, it will be presented this fall in local school and church auditoriums as the hospital's community outreach program is enlarged.

On a national scale, the tape was presented to the Canadian Pediatric Hospital's Association conference in Halifax. "A Child Life Program" is available to community groups and institutions across Canada on request.

For information, write: Donella Kaitel, Community Relations Section, Children's Hospital of Eastern Ontario, 401 Smythe Road, Ottawa, Ontario, K1H 8L2.

■ Childbirth Birth Day

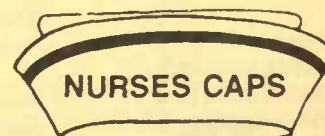
A 30-minute 16mm color sound film about childbirth from a mother's point of view. The environment and nurses and doctors are seen from the perspective of a mother as she enters the hospital, is prepped in the labor room and gives birth in the delivery room. Rental Fee: approximately \$40.00.

For information write: Lawren Productions Inc. 376 Wellington St. W. Toronto, Ontario M5V 1E3.



documentary on their Child Life Program. The videotape (filmed in color) is called "A Child Life Program" and shows the work done by the Child Life Department at the hospital. It includes glimpses of the library, kitchen, play programs and both craft and entertainment sessions. Throughout the film, child life workers, parents and volunteers can be seen teaching, comforting and playing with children on the ward. Highlights include the

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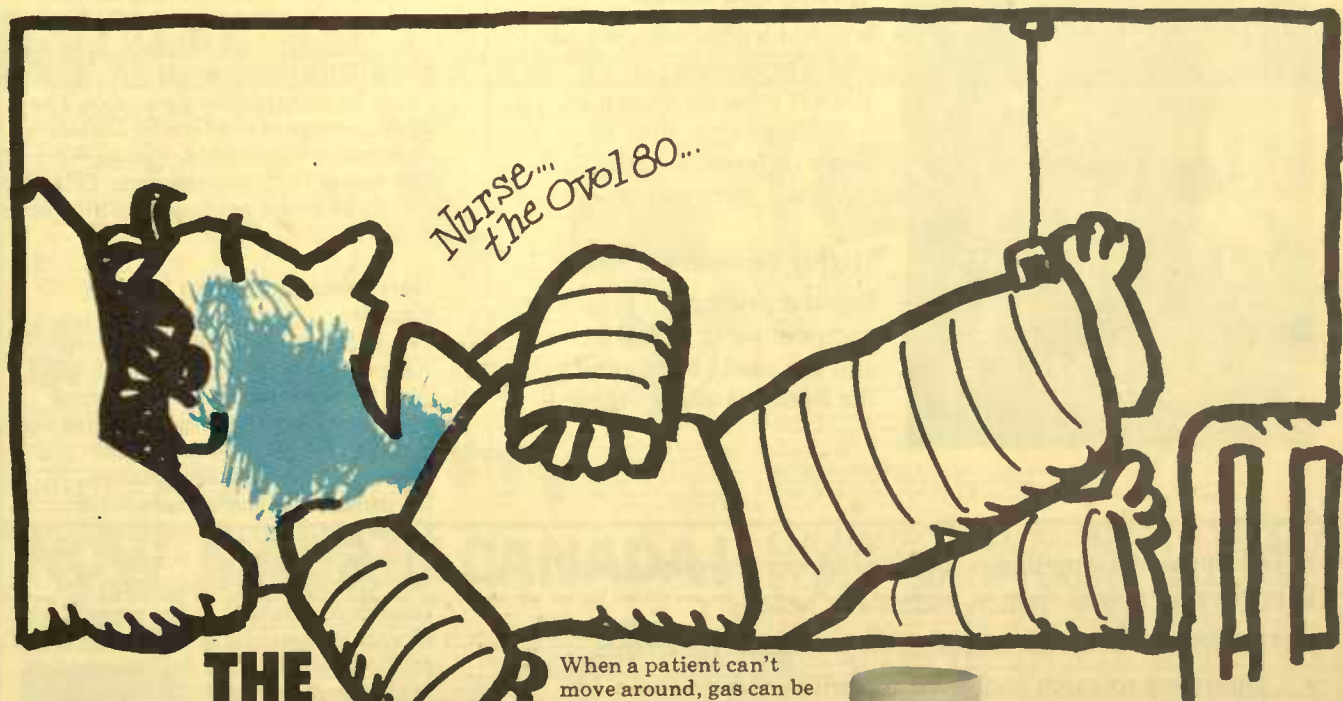
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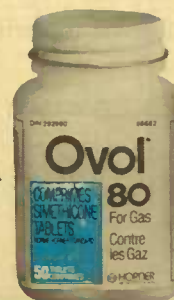
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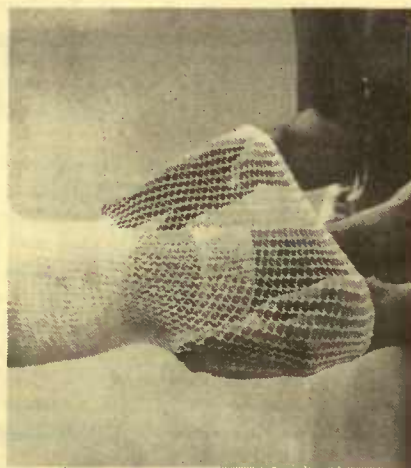
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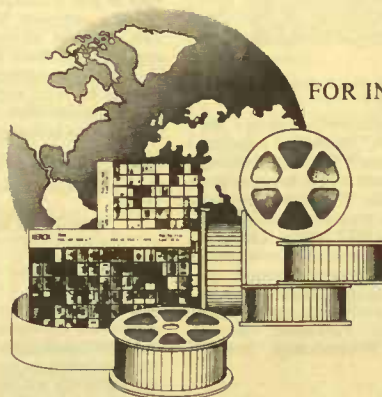
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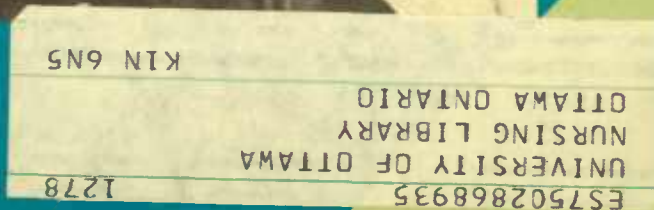
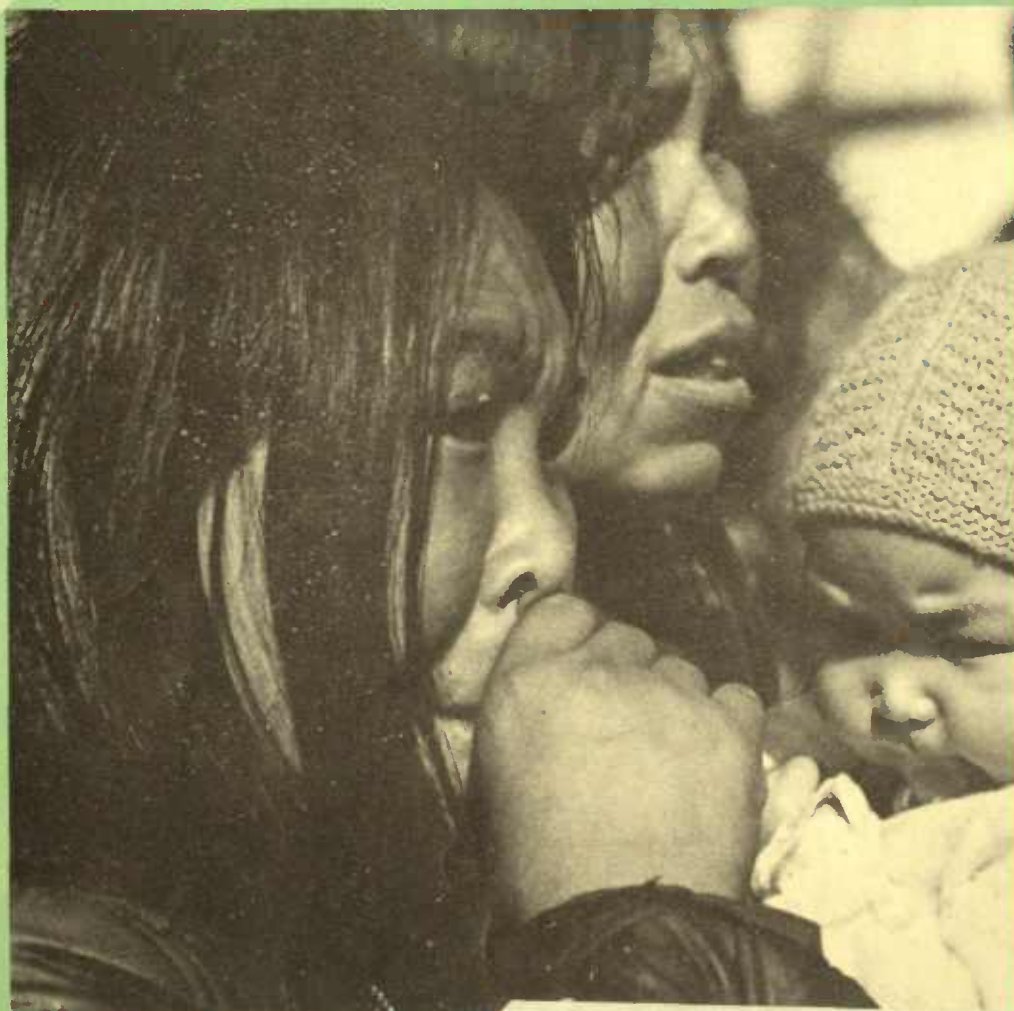
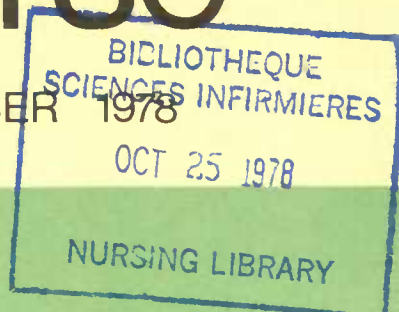
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The Canadian Nurse

October 1978

The official journal of the Canadian Nurses Association published monthly in French and English editions.

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No one can look at the lives of Canada's native people without recognizing that there are problems — very serious problems. In this theme issue of *The Canadian Nurse* our authors confront a number of concerns facing the native people of Canada. Are these people assured of quality health care? What role do we, as nurses, play in this health delivery system? What can be done to improve the health status of the native people?

Perhaps the first step is as simple as becoming aware of the problems as they exist. This month's cover photo was contributed courtesy of the International Grenfell Association.

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses Association.

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Perspective

Guest editorial



"It's the *quality* and not the quantity that counts." This frequently quoted statement has been around for a long time and is one which nurses often cite in defending their rights to provide good patient care. The artisan also strives for perfection in his particular craft and his fine workmanship is reflected in the object he has carefully created by his own hands. If he is forced to hurry in the creation of his work or to mass produce, his product might well come to serve as an example of mediocrity for others to imitate, and his potential contributions to his craft will never be realized. Thus the artisan's personal decision will influence others who follow and it is the craft which is ultimately affected. There are abundant examples of crafts which have become permanently modified over the years with fewer and fewer persons possessing the necessary skills to carry on the traditions.

Nurses are organized into a number of professional and interest groups. Through our varied expertise and our numbers, we can confront health care and health-related issues on many fronts. As an organized group we are perhaps only beginning to understand our capacities for influencing and making decisions that can determine

the kind of health care which should be realized for our citizens. We are learning that if we firmly believe something is appropriate for the common good, then we should speak out as a group. The nature and degree of our participation are important in determining the overall contribution which our profession will make to that care, as well as the type and scope of responsibilities which nurses will be permitted to assume in the work setting.

Let us not, however, make the mistake of depending only on collective decision and group action, especially when the issue is the *quality* of nursing care. Nursing care is given by individual nurses and we assume individual responsibility for our ministrations. Just as the expert craftsman plays an important role in determining how future artisans of his craft may perceive their art, each nurse affects our collective future. Patients generally evaluate the kind of nursing care they are receiving by assessing the individual nurses who provide direct care. The conceptual models which we develop, the organizational and management concepts which we employ, and the evaluative mechanisms which we adopt are necessary for us to plan and assess our services, but it is the individual's response within the established system which is critical for high quality care. Are you prepared to work constructively with others to help improve a situation where there is an obvious flaw in the system? Are you prepared to defend your personal and professional beliefs, even with your peers, when others want you to adopt a stance which you believe is not right? Are you willing to seek additional

information and knowledge so you will be better prepared to influence care and promote required change? We must continue to bring about changes in our profession and in our work, but these changes must occur through intelligent choices rather than through misinformation or by default.

There is, happily, considerable attention being given to the maintenance, development, and measurement of quality within our profession. It is an urgent matter, for at the same time we are being charged with responsibilities for cost efficiency and effectiveness. Resolutions which were adopted at this year's annual meeting of the Canadian Nurses Association in Toronto reflected the delegates' concerns to provide safe, competent nursing care and to promote education programs which will prepare nurses to meet the quality needs of our profession.

Resolution 6 called for the CNA to request the Department of Revenue to amend the provisions of the Income Tax Act in order that nurses and other salaried persons be granted tax exemption for monies spent in furthering their education in accordance with requirements for continuance in practice. (See *The Canadian Nurse*, July/August 1978, p. 55).

If you believe this resolution is important to nurses and that the quality of nursing care is influenced by our ongoing educational preparation, are you prepared to support this resolution as an individual? While CNA has communicated a request to the federal Department of Revenue strongly urging an amendment in the provisions of the Income Tax Act in order that nurses may obtain tax exemption for monies spent on continuing education

necessary for the exercise of their profession, the support of individual nurses would be invaluable. Can you spare a few minutes to write a brief letter to your Federal Member of Parliament? This seems to be an example of how organized nursing and individuals within the profession can support one another in the march toward quality.

— Helen D. Taylor, President, Canadian Nurses Association.

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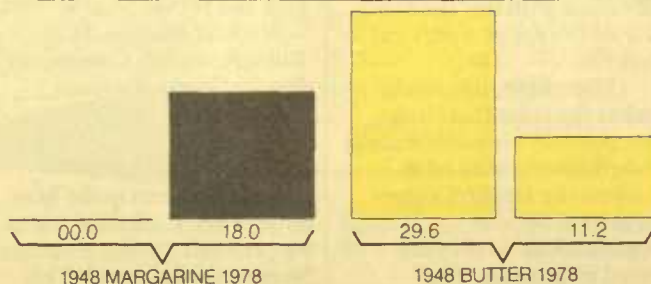
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Input

YOU AND THE LAW

Columnist Corinne Sklar will return in November with her regular feature, **YOU AND THE LAW**. Next month's topic — *"Teenagers, birth control and the nurse."*



Nursing in Labrador

I have found hospital nursing practice with the International Grenfell Association at North West River, Labrador diverse and challenging. North West River Hospital is just one link in the network of rural health delivery in Eastern Labrador. North West River cottage hospital, found on the shores of Melville Lake, acts as a referral center for coastal nursing stations.

The nurse here must have a broad knowledge of pediatrics, adult medicine, obstetrics, gynecology and geriatrics.

Due to the small size of the health team here there are many opportunities to pursue team approaches to patient care and teaching. This focus on patient care results in more consistent and comprehensive nursing interventions.

Occasionally opportunities become available for relief nursing in outlying coastal stations. This gives nurses unique exposure to the environmental backgrounds of the patients they see in the hospital. The hardships and joys of coastal life can be seen while nurses escort patients to and from their home communities.

Labrador is a place for professionals seeking a challenging lifestyle. North West River Hospital is a place that appeals to a 'different' kind of nursing professional.

My summer experience,

though brief due to university commitments, was professionally challenging and refreshing. I recommend Canadian nurses examine career opportunities in this 'other' part of Canada.

— *Christopher Lemphers, R.N., Halifax, Nova Scotia.*

Victims of the system

It was only today that I read your article on the Nurse Practitioner (April, 1978). It is clear that the Nurse Practitioner offers an exciting new dimension to our health care system. It is also clear that the program has been stifled by the present economics of the system.

Dr. King, of the College of Family Physicians, claims "Our provincial ministries of health did not provide the necessary funding mechanism so that the nurse could earn her keep so to speak and at the same time the physician not suffer a loss." I would take issue with this statement at least insofar as it pertains to Ontario.

Elsewhere, the article makes the point that Nurse Practitioners are economically and efficiently utilized in Community Health Centers (or Health Service Organizations as they are called in Ontario). The Ontario Ministry of Health launched the HSO program in 1973 and by early 1975 there were 30 HSO's in operation or final planning stages and another 60 with plans being

prepared. However, in March of 1975 the then Minister Frank Miller announced a freeze in funding. No new centers have been funded since.

It is very clear to those of us who have examined this recent history, that despite general government cutbacks the prime factor resulting in the freeze was the medical profession. Many doctors saw community health centers with their salaried doctors and nurse practitioners as a threat to their cherished fee-for-service system. Thus, it was the medical profession, permitted by the Ministry of Health, which dealt a severe blow to the nurse practitioner concept.

I agree wholeheartedly with Dr. Kergin's assertion that the future of the nurse practitioner depends on government action on fee-for-service. Nurse practitioners will find their true position in the health care system only when fee-for-service (or "fee-for-sickness" as it is sometimes referred to) is phased out. As long as a few privileged, licenced, individuals control the bulk of our health care resources with a stroke of their pen there will be little left for the rest of us who wish to design innovations in primary care and prevention.

— *Michael Rachlis, M.D., South Riverdale Community Health Centre, Toronto, Ontario.*

Study title changed

A news item in the May issue of *The Canadian Nurse* was entitled "Study Evaluates Nurses in the North." This item discussed the "Comparative Field Evaluation of Nurses Practicing in Isolated Nursing Stations," of which I am the principal investigator.

The title should have read "Clinical Training Program Evaluation."

It is true that in order to evaluate the training program we will be observing the care given by both groups of nurses — those who have had the course and those who have not had the course. However, since the project is not recording data by individuals, but rather by groups, no judgments can be made regarding individual nurses. — *Clarke B. Hazlett, Ph.D., Principal Investigator, Health Services, Administration Division, The University of Alberta, Edmonton, Alta.*

Administrators unite

The Nursing Administrators Association of British Columbia would like to establish contact with other Canadian groups of nursing administrators, who are organized either provincially or otherwise, for the purpose of exchanging ideas, and seeking input on common concerns in nursing service.

Our organization is autonomous and is comprised of top level nursing administrators in health agencies throughout B.C. We function through a Council made up of regional chair people from seven regions of our province plus an executive, and meet as a total membership annually for a business session and a specially planned educational workshop.

We would be pleased to hear of other Nursing Administrators Association groups. Please write to Mrs. H. MacRae, Corresponding Secretary, Nursing Administrators' Association of B.C., c/o Bulkley Valley Hospital, 3950 8th Avenue, Box 320, Smithers, B.C., or to Miss Elizabeth K. McCann, President, Nursing

The Canadian Nurse invites your letters. All correspondence is subject to editing and must be signed, although the author's name may be withheld on request.

Administrators Association of B.C., c/o School of Nursing, The University of British Columbia, 2075 Wesbrook Mall, Vancouver, B.C. V6T 1W5.

—Elizabeth K. McCann, president, Nursing Administrators Association of British Columbia.

Toe-touching query

I found the article written by George R. Kinnear and Kendy Bentley on "Fitness and You" (June, 1978) both informative and interesting. Many good points were stressed. However, I would like to comment on the first exercise which was illustrated — toe-touching, as a

flexibility exercise.

Dr. J.V. Basmajian in his book *Muscles Alive* 3rd edition, notes that "the back muscles do not always become active immediately when extension is begun from the fully flexed position" (p. 304). This results in the ligaments and soft structures in the spine taking all the strain as the muscles are no longer offering support. Fern Lebo in her book *The Fitness Myth* also stresses this point. Need I say more?

Flexibility is, of course, very important. One exercise which achieves stretching of the hamstring muscles without straining the back is sitting with one leg straight and one

knee bent. Reach towards the toes of the straight leg and hold in this position for a maximum of one minute. (Bending one knee causes a backward pelvic tilt which ensures good positioning of the low back with minimal strain).

—Barbara E. Perryman, Clinical Co-ordinator, Physiotherapy Department, Victoria Hospital Corporation, London, Ontario.

Did you know...

The American Board for Occupational Health Nurses Inc. holds certification exams designed to promote high quality nursing care in occupational health settings. The 1979 Certification Examination is scheduled for April 28, 1979 to be written in six locations including Toronto, Anaheim, Chicago, Atlanta, Philadelphia, and Dallas. For further information about certification, contact: Mayrose Snyder, R.N., COHN, P.O. Box 638, Thousand Palms, California, 92276.



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a statement on INDIAN HEALTH

Our people have travelled down a long difficult road. The pre-contact Indian people of this continent were extremely healthy and virile. Out of over 30,000 recognized diseases only 87 were known to exist, and then very rarely, among the Indians of North America. We lived in freedom from hospitals, insane asylums, police forces and prisons.

We were among the healthiest people on earth; we are now among the unhealthiest.

Indian infant mortality and suicide rates more than double the Canadian national average. Respiratory ailments, obesity, anemia, gall bladder infections, tooth decay, diabetes, alcoholism and other avoidable diseases plague Indian people in far greater proportion than the average Canadian (whose health level is by no means enviable).

The poor living habits of a dominant society have been adopted by virtually all Indian people. We now commonly disregard those basic laws the Creator has written in our natural world. Today thousands of our people subsist largely on commercially damaged and adulterated food products that have been clinically proven destructive to human health. Indian medicine people say that a return to the foods that belong here, as given to us by the

Creator, will return native people to a new strength.

Dr. William Saunders told me, "Indians fell prey to the white man's diseases not upon contact, as the germ theory would require, but after they changed their way of life. The Indian way of life was balanced and in harmony with nature, consequently the Indian people were healthy. When they introduced inappropriate measures from the white man's customs, imbalances were created and disease resulted."

Without question our people are suffering from unnecessary sickness and premature death. Is the best solution to our great health problem to be found in imitating a society whose people are seeking to erase their errors of living through drugs and surgery? Or is there a far less dangerous solution to be found in seeking to understand and pursue a path that follows the laws of life and health?

The elements of an unbounded success are wrapped up in the old Indian ways of health by healthful living. For the sake of our people we must accept the good things that white society offers but also reject much that has proven harmful or destructive.

—Raymond Obomsawin
National Indian Brotherhood
Health Coordinator.

Focus on NATIVE HEALTH



"We are all too familiar with the tremendous number of health and social programs implemented for our benefit which have been researched and written by people other than ourselves. We know that many have been shelved and that many have failed. How many times have we been asked if we feel a program is suited to our needs? How many dollars have been spent, supposedly on our behalf, where we were not involved in decision-making? I am fed up with being researched and written about and told what is good for me by strangers."

June Delisle administrative-director, Kateri Memorial Hospital Centre, Caughnawaga Indian Reserve, Quebec, to the Indian Nurses Committee Conference, August 26, 1975, Montreal.

The federal government currently operates 14 hospitals of varying size, 18 medical care clinics, 74 nursing stations and 130 health centers. These facilities are staffed by approximately 2,600 physicians, nurses, paramedical people and support staff. Medical Services Branch employed 760 nurses in Indian and Northern health facilities in January 1978.

The federal government does not recognize either a statutory or treaty obligation to provide health services to this country's native people. Nevertheless, there is a national policy to do so.

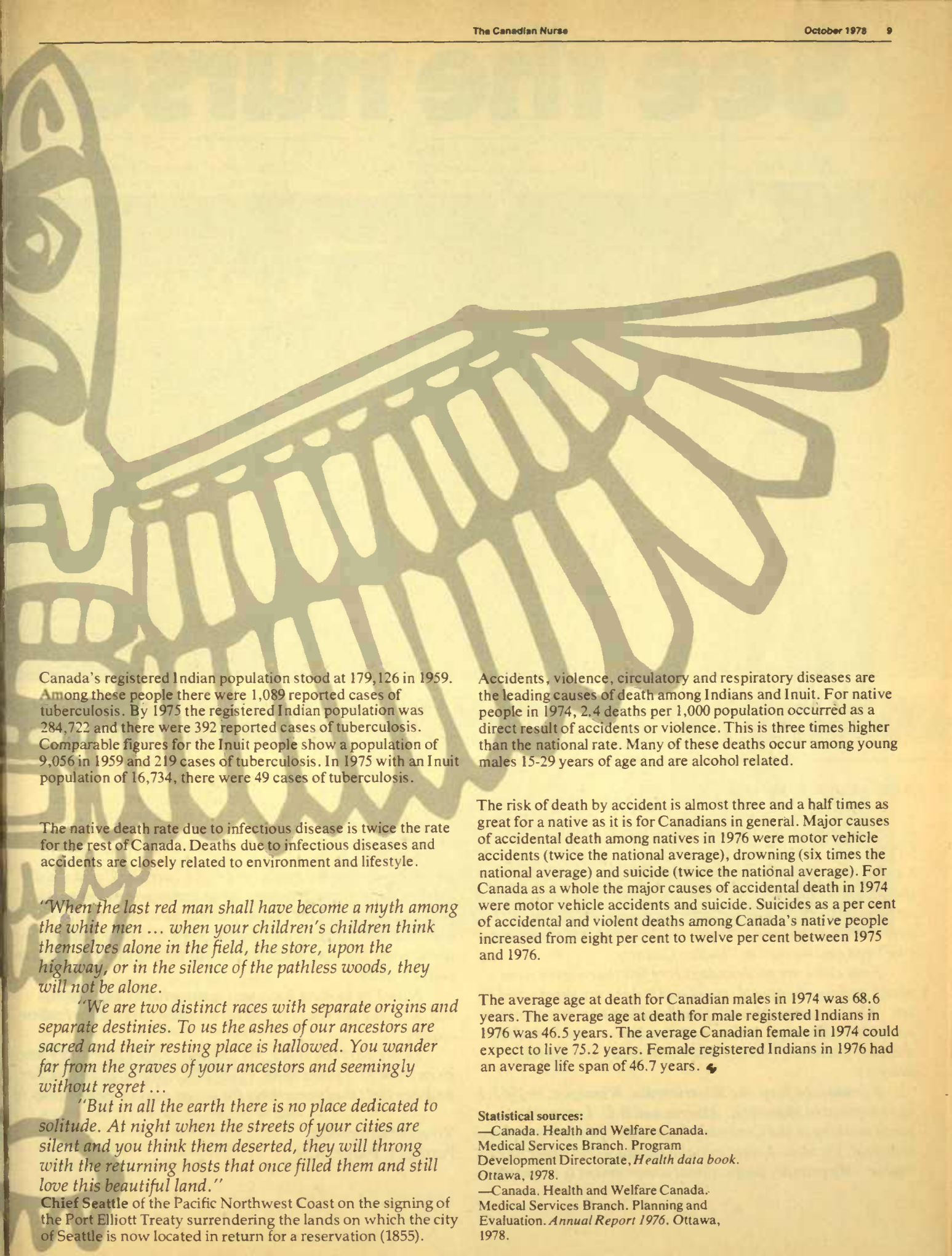
Indian and Inuit birth rates continue to be the highest in Canada. In 1976 they were almost double the national rate. Recently there has been a decline in infant mortality but the combined Indian and Inuit infant mortality rates are still more than twice the national average.

"I often wonder how much the nurses working among Indians know about Indians — as opposed to what they think they know. More important, how many have any idea, any awareness of their own unconscious prejudices and stereotyped thinking? Whenever our people seek health care, they are vulnerable to the unconscious racism of health care workers and they suffer accordingly. It is dehumanizing and degrading to be stereotyped in this way — as any woman ought to know."

An Indian nurse.

The Indian infant mortality rate in 1976 was 32.1 per 1,000 population, down from 38.6 per 1,000 population in 1975 and 79.0 in 1960. Health statistics from the Northwest Territories for 1977 show the infant mortality rate dropped to 32.2 from the 1976 level of 34.4. Infant mortality rates in the Northwest Territories have been reduced by almost 50 per cent during the past 10 years.

"In the beginning, the white man came to our island. He spoke to our ancestor, who was sitting on the end of a log. "Sit over!" said the white man. The old man moved a little, and allowed the stranger to sit on the log. The newcomer pushed him and repeated, "Sit over!" The Indian moved over a little. But it was not all. "Move over, I tell you!" And this happened over and over again, until the ancient one found himself at the far end of the log. The white man declared, "Now all the log is mine!"
Oral Indian story, "The White Man and the Indian"
(translated by Marius Barbeau).



Canada's registered Indian population stood at 179,126 in 1959. Among these people there were 1,089 reported cases of tuberculosis. By 1975 the registered Indian population was 284,722 and there were 392 reported cases of tuberculosis. Comparable figures for the Inuit people show a population of 9,056 in 1959 and 219 cases of tuberculosis. In 1975 with an Inuit population of 16,734, there were 49 cases of tuberculosis.

The native death rate due to infectious disease is twice the rate for the rest of Canada. Deaths due to infectious diseases and accidents are closely related to environment and lifestyle.

"When the last red man shall have become a myth among the white men ... when your children's children think themselves alone in the field, the store, upon the highway, or in the silence of the pathless woods, they will not be alone.

"We are two distinct races with separate origins and separate destinies. To us the ashes of our ancestors are sacred and their resting place is hallowed. You wander far from the graves of your ancestors and seemingly without regret ...

"But in all the earth there is no place dedicated to solitude. At night when the streets of your cities are silent and you think them deserted, they will throng with the returning hosts that once filled them and still love this beautiful land."

Chief Seattle of the Pacific Northwest Coast on the signing of the Port Elliott Treaty surrendering the lands on which the city of Seattle is now located in return for a reservation (1855).

Accidents, violence, circulatory and respiratory diseases are the leading causes of death among Indians and Inuit. For native people in 1974, 2.4 deaths per 1,000 population occurred as a direct result of accidents or violence. This is three times higher than the national rate. Many of these deaths occur among young males 15-29 years of age and are alcohol related.

The risk of death by accident is almost three and a half times as great for a native as it is for Canadians in general. Major causes of accidental death among natives in 1976 were motor vehicle accidents (twice the national average), drowning (six times the national average) and suicide (twice the national average). For Canada as a whole the major causes of accidental death in 1974 were motor vehicle accidents and suicide. Suicides as a per cent of accidental and violent deaths among Canada's native people increased from eight per cent to twelve per cent between 1975 and 1976.

The average age at death for Canadian males in 1974 was 68.6 years. The average age at death for male registered Indians in 1976 was 46.5 years. The average Canadian female in 1974 could expect to live 75.2 years. Female registered Indians in 1976 had an average life span of 46.7 years. ♣

Statistical sources:

—Canada. Health and Welfare Canada. Medical Services Branch. Program Development Directorate, *Health data book*. Ottawa, 1978.

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See the nurse

Patricia J. Floyd



About the author

In a letter accompanying this article author Patricia Floyd told CNJ:

I am a Registered Nurse, middle-aged, a single parent with three Indian children. I sold my typewriter the year I was left on my own — the kids were too young to leave. I am personally acquainted with poverty. For the last seven years I've lived and worked in "Indian Country."

Ever since my student days I've felt that nurses were pretty gutless about real issues and it does my heart good to see "The Canadian Nurse" finally willing to voice opinions on subjects like rape, poverty and sexism — now how about mercury poisoning, spruce budworm spray and drinking drivers?

I graduated from the Misericordia, Winnipeg, in 1961. I have worked in Manitoba, Alberta and B.C. I spent three years working in the Coronary Care Unit of Victoria General Hospital, Victoria. I went into the Indian world expecting to 'nurse'. My primary professional commitment is to health —

not disease-oriented medicine or sick care. So I've done all sorts of things from teaching adult literacy to helping fight bureaucracies for civil rights, patient advocacy, consciousness raising and organizing a day care center. I've spent years learning what forced our people into their present cultural state.

Now I'm looking for a university where I can get my B.S.N., take the courses I need, and keep my kids in Indian space.

In the past ten years, my children's life expectancy has risen from 37.5 years to 46.7 years (statistically). In this day and age isn't that something for us, as nurses, to be proud of

Yours in sisterhood,
Patricia J. Floyd, R.N.

See the nurse? The nurse is a university graduate. She is a Public Health Nurse. She works for the government. She earns a thousand dollars a month plus fringe benefits. She is very dedicated. She reads *The Canadian Nurse*. *The Canadian Nurse* says that nurses should be against poverty, because poverty is bad for the health. The nurse agrees.

Where are we going? We are following the nurse. She is going to visit the Indians today.

This is an Indian Reserve. See the houses? They are crummy. Why do the Indians live in crummy houses? Because the Department of Indian Affairs only allows ten thousand dollars per unit for housing. A crummy house is better than no house. Crummy houses are not a nursing problem, they are an economic problem.

Crummy houses burn easily. When someone gets hurt in a fire, that will be a nursing problem.

See the Indian? He is sitting doing nothing. Why isn't he working? Because there are no jobs. Why doesn't he collect unemployment insurance benefits? Because they say he isn't actively seeking work. Why isn't he? Because his car is broken and he has no money to fix it. Why doesn't he get welfare? Because employable adult males are not eligible for welfare.

It's ten in the morning and this Indian is drunk. Why is he drunk? Do you really need to ask?

See the nurse? She passes by on the other side of the street. That drunk Indian man is not a nursing problem: he is a social problem.

Here is the house where the drunk man lives. It is not his house. It is his father's house, but he lives here. So does his wife, their four children, his brother, his brother's wife, his brother's three children, his father, his mother, his sister's child that his mother is raising, and his grandma.

The house has three bedrooms. Grandma sleeps in the kitchen where it is warm. Why do all these people live crowded into one house? Because there aren't enough houses to go 'round. The Reserve got money for three houses this year. There are eighteen families on the waiting list. The drunk man is on the waiting list. The housing policies of the Department of Indian Affairs are not a nursing problem. They are an administrative problem.

Look! The nurse is going into the crummy, crowded house! She is going to teach health to the people there. She is going to teach about hygiene. She is going to explain that sleeping four in a bed is a health hazard. She is going to teach about nutrition. She is going to explain that a diet of rice, macaroni, bologna and tea is not good for growing children. Explaining these things is a nursing task. Explaining where they will get the space for more beds or the money for better food is not a nursing task.

The people are very polite. They let the nurse perform her nursing tasks. They do not swear or shout, or throw the nurse out.

Now the nurse is talking to all the people. She is telling them to boil the water from their taps.

The water in the taps comes from the creek. The fish the people used to eat came from the creek too, but all the fish died. That was after the industrial development and the subdivision were built upstream. The Indians thought they

might get jobs from the industrial development, but the personnel manager says they only want skilled workers. Discriminatory hiring is not a nursing problem. It is a legal problem.

The nurse tells the people they must boil the water from their taps, or their babies and old people will get sick and it will be their responsibility. The nurse knows the people cherish their babies and old people, so they will do what she tells them. The nurse likes it when the people do what she tells them.

The water from the taps is a nursing problem. The water in the creek is not a nursing problem, it is a political problem. The dead fish are a political problem too.

Now the nurse is going home. She has worked hard. She is a good nurse. She keeps her hands clean. She does not meddle with the tasks of other disciplines. She does not criticize other government departments. She does not get involved in politics.

She does not have to live on the Indian Reserve. ⚡



All photos courtesy of Health and Welfare Canada.



A Changing Relationship

George Wenzel

Statistics from Canada's North show a marked decrease in Inuit infant deaths, local control of tuberculosis and a decline in illness from parasitic infection. In many ways the northern medical service has met the physical needs of its clients. But what of their other health needs? Why have several Inuit people told this author they would not go to the nursing station because the nurses "dislike Inuit and stay inside all the time?" How can we change this perception?

Over the past thirty years Canada's North has seen major changes in terms of population, economy and ecology. Perhaps the most significant change has been the general rise in the level of health care among the indigenous people of this region, the Inuit. Anyone unfamiliar with conditions before the establishment of permanent northern medical services need only review the data on Inuit mortality and morbidity in order to gauge the impact this presence has had on the health of native northerners.^{1,2,3,4}

Southern Canadian interest in northern health has moved well beyond the problems which were seen as critical only a decade ago. At that time infant mortality, tuberculosis and public health were the essential priorities.⁵ Today, the northern medical establishment, reaching from local settlement nursing station to sophisticated southern urban facilities, is able to adequately meet most of the physical needs of the Inuit. But as the rate of social, economic and environmental change accelerates across the North, it has become clear that the scope of northern health care must also expand.

Southern Influence

For at least the last 4,000 years, the area from Alaska to southern Greenland has been occupied or moved across by a people who, in terms of race, economy and culture, are recognizable as Inuit. The part of Canada that the Inuit live in today shows a record of land use extending back some 3,000 years. Other areas, such as the northern tip of Newfoundland and the north shore of the Gulf of St. Lawrence, were periodically visited by Inuit. In contrast, European interest in the North American Arctic goes back only a few centuries and, in almost every case, this penetration was prompted by economic motivation.

It was not until the early part of this century that a permanent Euro-Canadian presence was established through much of the Canadian Arctic. Then, the welfare and 'control' of the Inuit rested with representatives of what is only half-facetiously known as the "Holy Trinity"; the church, the R.C.M.P. and the Hudson's Bay Company. Most often the health needs of the local Inuit were taken care of by an untrained member of

one of these organizations. More extensive medical care was available only at ship time in the late summer when the resupply or government ship put in at each community. The long-term transferral of Inuit patients to southern health care facilities (sometimes for periods of up to three years) had significant cultural, as well as medical, impact.

A permanent health delivery system was established in the North for several reasons. The first was the series of epidemics and famines which swept the Inuit living on both the east and west shores of Hudson Bay in the late 1940's.⁶ This led the Canadian government to move much of the Inuit population of the Eastern and Central Arctic into a number of permanent settlements, rather than camps scattered over the land. This centralization began in the early 1950's and continued well into the 1960's.

After the Second World War the strategic position of the Canadian Arctic meant large numbers of non-Inuit would, for the first time, be living in the North. A series of radar stations (known as the DEW line) and airports were built. At the same time it became obvious that these sites, with their improved facilities, were ideal locations for relocated Inuit. Other villages were placed near established Hudson's Bay Company stores where there were often good deep-water harbors.

With these changes the northern medical service settled down to the task of meeting the physical health needs of the Inuit. An important element here was the outpost nursing program. Improved transportation and communications simplified patient transferral south but it also gave the Inuit a chance to receive needed medicines and health care in their home communities. The results of the outpost program are obvious when you look at the marked decrease in infant and mother's deaths, local control of tuberculosis and the decline in deaths or serious illness from parasitic infection.^{7,8,9} New physical problems related to settlement life and increased contact with the South (e.g. dental hygiene, public health and poor nutrition) are slowly being overcome.

The health establishment in the Arctic has maintained a focus on the physical problems which have accompanied cultural change but the establishment appears to be less prepared for the non-physical problems which accompany modernity.¹⁰ Researchers have studied the effect of southern contact on Inuit socialization

and interpersonal behavior.¹¹ It is unfortunate that the relationship between these factors and Inuit health has been viewed as separate from the real purpose of the present health care system.

Several events have emphasized southern Canada's ability to affect life in the North. In 1975 Brody looked at the social relations in a modern Inuit settlement.¹² Events move so quickly in the North that only a few years later another researcher saw significant changes in the pattern of social relations in the same community.¹³ These changes were recognized after the introduction of wage employment by a major petroleum company.

Changes of a socio-economic nature are relevant to understanding Inuit medical needs.^{14,15,16,17} The fact that such "social" problems as child and spouse abuse, alcoholism and emotional stress contribute greatly to the work load of the settlement nurse underlines the extent to which problems associated with cultural changes or modernity affect northern health workers.

The Inuit in the System

To a large extent the relationship between the Inuit and the health care establishment in the North has changed, just as the types of medical problems have changed. Exactly how this change began is difficult to pin down, but in my view this shift is critical in terms of assessing the effectiveness of the present system.

In 1975 I was asked by the Committee for Original Peoples Entitlement to prepare material for presentation to the Mackenzie Valley Pipeline Inquiry.¹⁸ I studied the adequacy of the health delivery system in the Mackenzie Delta area in light of the Alaska Pipeline experience. I could not help but be struck at that time by the Inuit peoples' observations concerning the quality of their health care system. I was forced to conclude, along with other observers,¹⁹ that the reservations expressed by the Inuit about the health care system show they feel medical services are no longer concerned with native people. The fact that similar observations have been made in the Eastern Arctic points out the seriousness of this situation.²⁰

Dissatisfaction with the health care system must be placed in historical context. Aside from the rare missionary medical clinic or hospital (such as those established at Aklavik, Chesterfield Inlet and Pangnirtung) the stationing of resident health care personnel in small northern communities began with the outpost nursing program in the late 1950's and early 1960's. The conditions under which nurses operated at this time placed them in close contact with the population they served. As one resident of Tuktoyaktuk put it:

*"Twenty years ago we saw much more of the nurse. The people were very spread out and the nurse often visited each home each week. Today we have three nurses and they have a car and skidoo. But we hardly see them. If someone calls in the night they say he must walk to the station or wait until morning."*²¹

This feeling of a loss of contact between the nurse and the Inuit is perhaps the most notable comment on the Inuit perception of the medical establishment. Sachs Harbour and Clyde River are communities with 170 and 325 inhabitants, respectively. Both communities were served by single nurse stations at the time I did my interviewing. Over and over again Inuit residents of these settlements told me how important frequent encounters with the nurse away from the station were to them.²² In several other communities the Inuit said they would not go to the nursing station because the nurses "dislike Inuit and stay inside all the time."

A second factor which contributes to this perception of a loss of contact is the rapid turnover of outpost and northern hospital personnel from year to year. While the ratio of trained medical staff to population in the Mackenzie Delta at the time of my report was certainly sufficient for adequate care the continual replacement of personnel, particularly at the nursing station level, was often mentioned by the Inuit people as a reason for this perceived "dislike of Inuit." Health and Welfare Canada figures (1960-1970) indicate that the rapid displacement of health care personnel is a chronic problem in all the health zones in the Northwest Territories.²³ My conversation with one zone director revealed that he expected a 75 to 85 per cent turnover in nursing staff at all stations in a single year.

Photo courtesy of Health and Welfare Canada.



When we compare this to the Inuit experience in the 1930's, 40's and 50's it becomes easier to appreciate the impact staff turnover has upon Inuit perception. At that time, non-Inuit, whether church, government or Hudson's Bay personnel, often maintained residency in a community or area for several years. During these years the Inuit also had closer contacts with Whites because, in a very real sense, Whites were dependent upon the Inuit for food, transportation and equipment.²⁴ This recently changed relationship is important to this discussion because it points out a unique independence which has grown among the brokers of a service of great importance to the Inuit. One Inuit man from Churchill said: "... before, when Roman Catholic priests, nuns and doctors were treating the Inuit people there was a better relationship between the patient and the doctor (or nurse). The treating personnel were curing and comforting the patients. Ole asked if it was possible to come back to that kind of relationship between nurse and patients."²⁵

Several other elements such as the role of the Inuit communities in the health care system, employment of more and better trained native personnel and North-South liaison in the medical context are of extreme importance in terms of Inuit health care.

Close group cooperation along broad kinship and economic lines has formed the core of the Inuit society. Several researchers have pointed out some of the problems and advantages of including native people in the health delivery system.^{26,27}

Conclusions

The problems of culture change in the Canadian Arctic cut two ways. On the one hand studies on the effects of acculturation and modernity have shown that a whole new set of health problems are arising in the North. On the other hand critical analysis of the health care system shows that serious problems associated with southern induced technology and communications are having their effect on the relationship between northern medical services and the population it is in place to serve.

Justice Thomas Berger in the second volume of the Report of the Mackenzie Valley Pipeline Inquiry cites two primary areas of concern in this relationship.²⁸ The first is that a persistent lack of communication between health care professionals and the Inuit is developing. The second is that the health care establishment in the North has allowed itself to focus too strongly on certain problem areas while new problems await sufficient personnel and funding.

Difficult problems are already at hand. The competence of the system is not in question, rather it appears to be a perception problem. The outpost nurse is an integral element in the North's health care system. Researchers note a variety of problems that the nurse faces (including communications) which make liaison with southern colleagues difficult.²⁹ But in the evolving situation in the Arctic, more and more the real problems of communication are occurring within the local Inuit communities themselves.

Without an appreciation of the fact that the Inuit and other native northerners are not southern Canadians, very little can be done to improve the nurse's relationship with the population

she serves. Language, social structure, economy and ecology are all factors which are important in shaping Inuit perception of an environment of which health services are a part. The necessity of being aware of these factors is obvious if Inuit, nurses and other health professionals are to unite to meet these new needs. Nurses are representatives of a class of Southerners who have historically had an impact on the Inuit far exceeding their numbers. Respect for the nurse's own potential to influence change, not only in the health field, but also in other aspects of Inuit life, must always be kept in mind. ♣

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George Wenzel, the author of "A Changing Relationship" is on staff at McGill University's Centre for Northern Studies. Wenzel began northern research in 1968 as an archeologist in the Yukon Territory and Alaska. In 1971, he shifted his research emphasis to human ecology and spent 18 of the next 36 months at Clyde River, on Baffin Island studying hunting and native economy. He conducted a study in 1975 on the health delivery system in the Mackenzie Delta area for presentation to the Mackenzie Valley Pipeline Inquiry. Wenzel is now researching the effects of wage labor on indigenous Inuit economies.



Social Considerations in Northern Health Care

Gaile P. Noble

I worked in the Indian and Inuit communities of the central Mackenzie River Valley and the Mackenzie Delta for three and one half years. While I was there the work of the settlement nurse and the social worker frequently overlapped: health problems in the North are often both medical and social in nature. As a social worker I cannot pretend to be an expert in northern health care but I do have some thoughts on the special circumstances and problems involved in northern health care delivery.

The settlement nursing station plays a vitally important role in health care delivery in the Western Arctic where there are usually no roads connecting settled areas. Isolated communities depend upon small bush planes for transportation and supplies. The settlement nurse is usually the only

person in the community with any medical knowledge and she is often alone. The nurse is on call 24 hours a day, seven days a week. This means, in anticipation of emergencies, she cannot venture far from the nursing station.

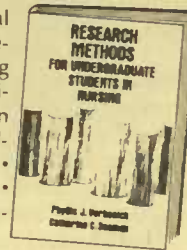
The nurse carries a heavy responsibility when communication with

the regional hospital for consultation with a doctor is impossible. Planes cannot fly to evacuate an emergency case in bad winter weather so the nurse must cope as best she can with the critically ill or injured. This is further complicated in settlements where people speak little English and have a limited

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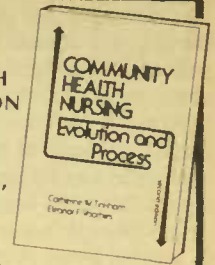
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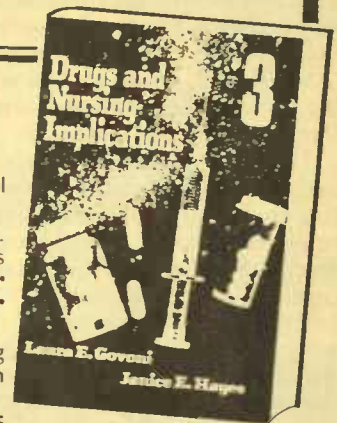


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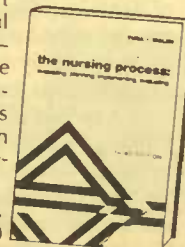
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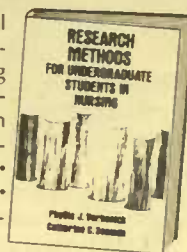


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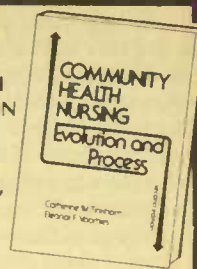
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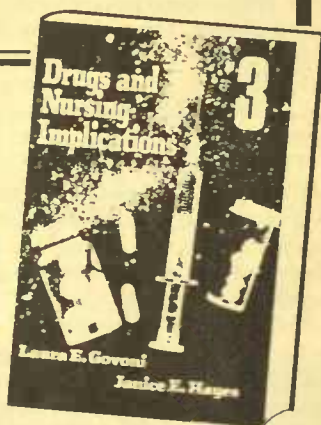
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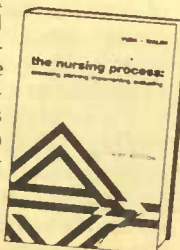
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understanding of health disorders and treatment.

As important as these factors are to the delivery of health care I suggest that a more critical factor is the social environment in which the northern nurse must work and live. Increasingly the health problems of the North are not such killers as influenza epidemics and tuberculosis but ones in which social and psychological factors are important such as alcohol abuse, violence, mental health problems, venereal disease, child neglect and abysmal dental health. This situation is made worse by substandard and overcrowded housing, poor sanitary facilities and waste disposal and insufficient supplies of safe drinking water.

The nurse finds two social worlds in the North, that of the majority native residents and another of the minority non-natives. With few exceptions she finds that the non-native residents are relatively young, employees of the federal or territorial governments and highly transient. They are in the North to provide services to the native population be it health care, education, law and order, economic development or local government.

This non-native population is usually physically separated from the native community in housing that is comfortable, modern with all the usual utilities and far less expensive than comparable housing in southern Canada. All this is due to government subsidization. These people often make more money than they would in the South and, at the same time, receive the substantial benefits of a northern living allowance, subsidized vacation travel, along with higher education benefits for themselves and their children. Many have little or no commitment to the community or to the North; the turnover rate among non-natives in the North is very high.

There is a strong temptation for settlement nurses to retreat into this white community, maintaining a southern "nine-to-five" clinic schedule and a very distant relationship with native people. This is difficult for native people to understand. They are not on a southern time schedule, most have never had a steady nine-to-five job, and important activities as well as social relationships take place in the afternoon and night. A strong resentment develops when the nurse tells a person to "come back tomorrow, you missed your appointment and the nursing station is closed."

While this sort of behavior may be understandable it is not conducive to solving native health problems nor does it build a basis of trust with native people which is essential if health education and effective treatment are to take place.

I do not mean to be unduly critical of

northern nurses. I have seen many dedicated and effective nurses in northern communities who have stayed a number of years, are trusted by the community and interact freely with native people. Nonetheless these are factors which have to be taken into consideration.

A second aspect of the northern health scene which I think many health personnel fail to understand is the rapidly changing social and economic scene. These changes have resulted in a series of violent shocks to the native society and culture and have affected their physical and mental health situation. Northern native people have seen their lives turned upside down in the last 20 years. In place of a nomadic existence based on the resources of the land and water the government has resettled the Inuit and Indians in permanent communities. Money and wage employment, unemployment insurance, family allowances, welfare, southern television and radio and store-bought food have all been recently introduced to this area.

I think it is often very difficult for people coming from southern Canada, be they medical or education or local government personnel, to appreciate the enormity of these changes in terms of native culture, family structure and mental health.

Health care in the North has shifted from treatment of communicable diseases such as tuberculosis and influenza to those of a more social basis. Today native people eat a starchy and sugar-filled diet of commercial bread, rice, potatoes and a constant intake of sweets.

Where once Inuit and Indian people had almost perfect teeth with a diet of meat and fish, it is now commonplace to find 30-year-old adults with false teeth and children of four or five with a mouth full of rotten teeth. The limited number of dental personnel in the North are too overwhelmed by dental emergencies — there is simply no time for normal dental examinations and cleaning.

Another more critical aspect of the northern health scene is the relationship between alcohol and mental health. As Dr. Otto Schaefer demonstrated in his testimony before the Berger Commission, per capita alcohol consumption in the Northwest Territories has increased steadily throughout the 1960's and early 1970's closely paralleling the increase in wage employment, oil exploration work and the increased percentage of deaths due to violence.

These facts do not show us the suffering and misery of the native people, nor do they show us what it means to be a nurse trying to deal with them on a community level. We have to look at individual cases — the young

father of three who died when his snow mobile hit a wooden fence, while he was drunk; the mother of four whose jaw was broken and her children beaten by a drunken husband; the parents of a young Indian who killed three of his relatives and then committed suicide when he was drunk.

I do not mean to say that northern settlements are filled with violence. They are not. But in many communities that have been exposed to southern culture and high wages these problems do exist.

Nor do I wish to create a totally negative picture of work in the North. It is, in fact, a very positive sign that Inuit and Indian people are moving to take control of their own communities and deal with the social and health problems they regard as important. This has meant that non-native nurses, school teachers, doctors and government administrators are no longer regarded as ultimate authorities in matters of health, education and welfare. Non-native professionals must be ready and able to work on a cooperative and equal basis with native people who do not possess the same educational and professional qualifications.

I believe that the nurse going to work in the North must be prepared for a very difficult and complex scene both medically and socially. It would be of real value if non-native nurses could receive more of a practical and community-level orientation related to the real world they will have to face in the North. ♡



All photos courtesy of Health and Welfare Canada.

The author of "Social Considerations in Northern Health Care" Gaile Noble is a social worker living in British Columbia. Until recently Noble was on staff at the school of social work at Memorial University in Newfoundland.

Recollections of Native Health Care



Photo courtesy of Health and Welfare Canada.



Mike Doxtater

There are no horror stories in my own experience. I know of no cases, at least not publicized ones, of gross negligence. I've heard of no scalpels sewn inside after appendectomies ... no lances left in boils ... no fingers stitched on upside down ...

nothing that bizarre.

No one has disappeared without a trace, as far as I can remember.

So what is there? How would I, an Indian, describe my view of medical care?

Health care on Indian reserves is as you'd expect treatment would be in Third World countries. For the most

part that's what a reserve is — several square miles of territory in North America serving as a constant reminder that affluence does not abound everywhere on the continent. There are still those who exist but by the grace of government. Health care represents part of the new welfare society.

Dr. Kwong (that wasn't his real name) is dead now. He died several years ago. But he was the doctor at our local clinic after the reserve hospital was closed down. It was rumored he served in the Japanese army during the second of this world's two major wars. On Remembrance Day he'd march with the

Indian veterans. There is some kind of irony there. If we can believe the anthropologists, it's just a case of his joining his descendants after that long trek across the Bering Strait in antiquity.

We used to wonder why no one let him carry his country's flag.

He always wore a brush-cut. His hair was peppered when I first went to his office for treatment. He had oriental features. He also wore silver framed glasses even before it was fashionable. Someone said they were safety glasses.

He talked funny. After every phrase he'd suck wind through his teeth. "Well, thththth, what have we here, ththththth," he'd go. "Let's see what the chart says, ththththth." Then he'd read for awhile. "Hmmm," he'd respond to what he'd read. "Take off the shirt, thththth."

Even when he had nothing to say he'd "ththththth."

One time a young girl I knew went to see him about a bad cold. Several times a day people with bad colds would visit the doctor. It wasn't unusual for treatment of colds to dominate his day. It was the best excuse one could concoct to miss a day's school. Headaches aren't really that easy to explain away. There is a myth that a slight fever accompanies a headache.

Then there are more severe ailments. A viral diarrhea gets around pretty quickly on a reserve which, up until a couple of years ago, was serviced exclusively by outhouses. Pneumonia also winds its way through a reserve whose houses, up until a couple of years ago, were heated exclusively by wood fueled stoves.

So there's this girl, see.
And she goes to see good old
Doc Kwong.

“Take off the clothes and lie down on the table, thththth.”

"But..."

"Let's have a look at the chart, ththththth."

"But ..."

"You know there's a lot of scabies going around, ththththth."

"But ..."

"So, ththththth, I'll have to examine you, ththththth."

"Excuse me doctor."

"Yes, thththth?"

"I have a sore throat."

"Thththththththt..."

Health care is a touchy topic. Some people say we shouldn't complain about something we're getting for free. Until we pay for it ourselves we shouldn't look this gift horse in the molar. Even the Ontario Hospitalization Insurance Plan is a gift for a lot of Indians. Students, the disabled, abandoned and unemployed all get their OHIP free... at least it's paid by somebody else.

Indian infant mortality, the highest in North America, may be a symptom of poor social conditions. An Indian male can expect to live to 46. Reasons here are myriad. We've gained eight years life expectancy during the seventies. That is reassuring. But don't congratulate the health care people. The cross-cultural pull between the Indian and western European society is ebbing. Indians can cope with cars, television, work, money, food, affluence, a little better. That's all. Health care has little to do with it. Indians have learned to cope by themselves.

Since OHIP, people have started to avoid the reserve clinic. Those with transportation can now exit to nearby cities where health care is professional, utilizing professional healers. You have your appointment, show up and are treated as a human, not a statistic. My mother would have died from cancer had she not gone outside the reserve for an examination.

Apathy, I think, is the best way to describe what happens to doctors charged with the health maintenance of Indians. It's a creeping complacency catching the most committed of physicians. It takes hold. It is dangerous.

Dr. Deutche (this name has also been changed) worked on the reserve 20 years with Dr. Kwong. After Dr. Kwong retired, Dr. Deutche was head physician at the clinic. He was bald and had a harsh south German accent. The only thing missing was a monocle. "Was ist den los," he'd mutter to himself. "Das ist nichts."

No one knew what he was saying. Some thought he was finding some hidden disease dooming a patient to a life of ill-health. Later I learned he was only telling himself the patient had nothing wrong.

I often wondered whether Dr. Deutche was playing 'god' or Dr. Livingstone among the natives. He'd lecture patients about wearing better clothes, or eating more fruit and less potatoes. He'd send you out of the clinic if he thought there was nothing wrong with you. I don't think he'd ever smiled in his whole life ... well, maybe once.

"I stepped on a rusty nail."

It went clean through my foot. The pain was of the throbbing variety, immeasurably worse than any toothache. My foot was only comfortable if it was higher than the rest of my body.

"Ach," he said, then broke into the broadest smile he'd had in his life.

He turned to look at the foot. It was tenderly adorned with a sock. Yank went the sock.

"Yeow," went my whole body.

"Heh, heh," went Dr. Deutche.

"Vell," he said finally.
"Dat ist a very nahsty

vound."

"Ja es ist," I might have replied had I not slipped very close to unconsciousness.

"Vell ve goona take a loook in zee vound, und try und detairmine zee extent off zee injury."

Look he did. A poke with the finger. A jab with what looked like an instrument for tooling rawhide. A dab with alcohol.

"Yeow," went my whole body.

"Dat ist not zo bad."

He went out the door for a moment. A reprieve, I thought. "Yeow" is what I

thought. "Now" is what I said. My foot was throbbing now, like a land mine ready to explode. The foot has thousands of bones in it. I was picturing someone trying to piece my foot back together after the blast. He returned.

"You will haff to pull down zee hosen, I mean trousers for zee tetanus shot."

He liked that word, "shot." He didn't administer the shot. A 300-pound nurse, looking like a former jammer with the roller derby, did the honors.

"You have thick skin down there," she said indicating the amount of effort it was taking to push the needle into the buttock.

I think I said 'thank you,' I don't know why.

Dr. Deutche wasn't around then. I heard "yeows" from another room. I knew I was safe for now.

Always the treatment and medicine was the same. No matter what ailment was afflicting you, he'd examine you, an ice-cold stethoscope sending shivers all over you. He'd look down your throat. He'd look in your ear. For some strange reason he'd look into your eyes and nose. There were the traditional taps on the back. He'd reach up with his two cupped hands placed antiseptically around your jawbones. Doctors always seem to have clean, cold hands like they wash in ice water ... maybe ice water does flow in their veins. He'd scribble something on the chart, then send you out in the waiting room.



It was usually crowded so you'd have to stand by the door with several other people. People would always examine you themselves to see if you were sicker than they were. Anyway, you'd wait for your medicine handed out from the clinic's dispensary. You always knew what the cure would be.

You think "take two aspirins and call me in the morning" is a line from some comedian's Vegas routine. It was Dr. Deutche's clarion call. For stitches he'd prescribe aspirin. For hematoma, aspirin. For diarrhea, aspirin. For ingrown toenails, aspirin. But there was more. Sulphur tablets were always shelled out with the aspirin. I have never, even to this day, been able to find out what sulphur tablets do.

Preventive medicine never had it so good.

On the whole, health care on the reserve has not been that bad. All hypochondria aside, I feel pretty good today. After all I'm alive, ain't I. Do we congratulate the clinic? No. Do we congratulate ourselves? Yes. You get through the best you can.

Health care is a psychological crutch enslaving Indians, another market for Big Medicine. It's all Big Business, really. The doctors on reserves aren't doing it out of the kindness of their hearts. No matter how strong their social consciousness, money is still the great motivator. In fairness, we all have to eat. A lot more people get to have gravy on their french fries than a lot of Indians.

It's changed now though. Ten doctors, all young, take half-day shifts at the clinic. They seem to care a lot more. They don't seem to be the distant brooding doctors of the Christian martyr syndrome mould. You have to telephone in for an appointment. But hardly anyone ever does. The medicine is a lot different. You don't get aspirins unless you ask for them. Birth control pills are offered free. That's good.

What's it all mean? Simply, Indians are being treated just the way every other Canadian would expect. This isn't the Third World you know. Indian reserves are in North America. Maybe someone up there in Ottawa finally thinks an Indian is a human being.

Roger Jones

Health care is everybody's concern. None of us has perfect health.

But for people who often live in poorly ventilated, inadequately insulated housing; who have not been taught proper nutrition; whose life expectancy is fully 30 years below the Canadian norm, health care is a predominant concern.

Or it should be.

It is not uncommon for large numbers of Indians on reserves, especially older people, to suffer almost perpetually from diseases such as influenza and pneumonia.

But many of these people would rather suffer than seek the services of a doctor. Too often their experiences with doctors have discouraged them from seeking medical help.

Elders complain that when they are persuaded to go to a hospital for an examination or for treatment they are unable to communicate with the doctor.

Rather than try to alleviate this problem, the frustrated doctor, mindful of the crowded waiting room outside his office, will simply write a prescription for 222's* and nose drops so that he can go on to the next patient.

The patient returns home and takes the medication. There is no relief. This causes the people to lose their faith in the doctor and his medicine, and the whole health care system.

Lack of communication is not the only reason many Indian people have a negative attitude toward white medical services. The medical and personal treatment they receive from doctors and hospital administrators is another contributing factor.

For example, "Village General," 20 miles from my reserve, should serve our people. It doesn't because five years or so ago the Indian people became disillusioned with the treatment they were receiving there. Several specific cases prompted us to seek out new medical facilities and, for three years, until a clinic was opened in a nearby town, people from my reserve drove 60 miles to another hospital in a larger center.



Before the construction of the new clinic the basement of Village Hospital served as a clinic. A long hallway served as the waiting room for the two examination rooms.

Before my tonsils were removed about five years ago, I had an attack of tonsillitis like clockwork three times a year in February, July and December.

I can remember waiting, with my mother, for hours and hours in that hallway. I was waiting for an examination. The prescription was always for penicillin. But that didn't seem to work as well as the medicine my mother would make by boiling some kind of bark in water. That stuff seemed to burn the infection away.

It wasn't until we went to the new clinic that somebody decided to perform a tonsillectomy.

I can remember spending at least a month in Village General when I was seven or eight years old. I was losing what seemed like buckets of blood through nosebleeds but nobody seemed to know what was wrong.

When I finally left the hospital, my mother and I went to see an elder on the Birch Island Reserve about 35 miles away. Everybody would go to see this man when they were sick. All I can remember him saying is that I wasn't going to die.

It was not unusual to see 10 to 15 native people waiting to see the doctor at Village General. They always seemed to be the last attended to.

In a recent interview, Chief Wilfred Owl of the Spanish River Reserve spoke of his experiences with the hospital and those of his band members.

"I never had any problems with the hospital," said Owl. "It was because I was a chief and they saw my position as being that of a political leader."

"But that doesn't mean I'm not aware of what went on when other people from the reserve sought medical help."

There was a case of an elderly Indian woman named Lucy who was taken to the hospital after a lot of resistance to the idea. After a long wait she was finally examined, given her prescription, and sent home.

"A few days later this woman died of double pneumonia," said Owl.

Joe, an elderly man in his 60's, could always be seen walking on the reserve road, either to or from town. Rain or shine, Joe was on the road.

Joe was not one to bother anybody. So when he came down with a case of pneumonia, he took care of himself. He had done it before. Only this time he wasn't getting any better. This prompted his neighbors to suggest he should see a doctor.

He was taken to the Village General where he was given a prescription for 222's* and sent home.

Joe was found dead two days later in his one room shack.

The job of reserve constable is not very easy. It can get rough at times. Two constables are employed by the band to enforce the law.

Owl spoke of an incident which occurred on the reserve involving the two Indian constables. "The constables pursued a stolen vehicle and apprehended two young men from the reserve," said Owl.

"However the arrest did not go without a scuffle. One of the constables was struck in the jaw by a club. He was taken to the Village General for an examination and told he was fit for duty," said Owl.

On their return to the reserve the constable driving the cruiser noticed that his partner was in obvious pain. He drove 60 miles to the city to have his partner examined again.

The constable was found to have a broken jaw and a bad concussion. He was off duty for six months.

It was after incidents like these that the reserve people started to avoid the Village General. Then a proposal for the construction of a medical center in a nearby town was brought to the attention of the chief and band council.

The reserve paid one-third of the cost of construction, obtaining a grant from Health and Welfare Canada and from private donations from the people of the reserve.

*Registered trademark.

The medical people who staff the new medical center are from the hospital 60 miles away.

"The ideal situation would be to have our own clinic on the reserve," said Owl "and that is what we'll be striving for in the near future."



Photos courtesy of Chris Laporte.

Author Mike Duxtater is a 25-year-old Mohawk from the Six Nations Reserve near Hamilton, Ontario. Mike is a third year history student at McMaster University in Hamilton.

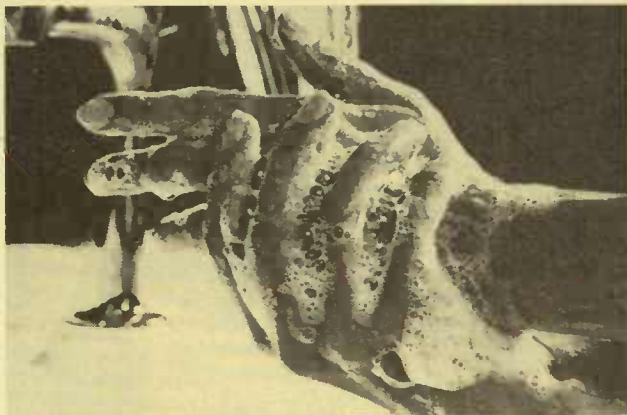


Roger Jones is a 20-year-old Ojibway from the Spanish River Reserve in Massey, Ontario (100 km. west of Sudbury). Roger is a third year political science student at Laurentian University in Sudbury.

Both authors were students in a Band Information Officer Training Program in Ottawa last summer. Operating on an experimental basis for the past two summers, this program was designed to train status Indians in both print and broadcast communication skills. The success and future of this course will be evaluated by the federal Department of Indian Affairs at the end of this year.

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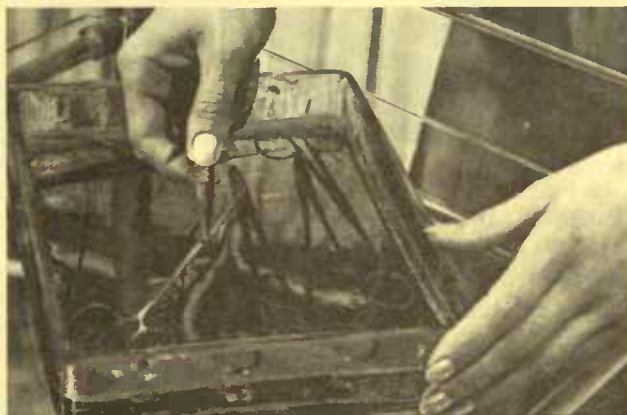
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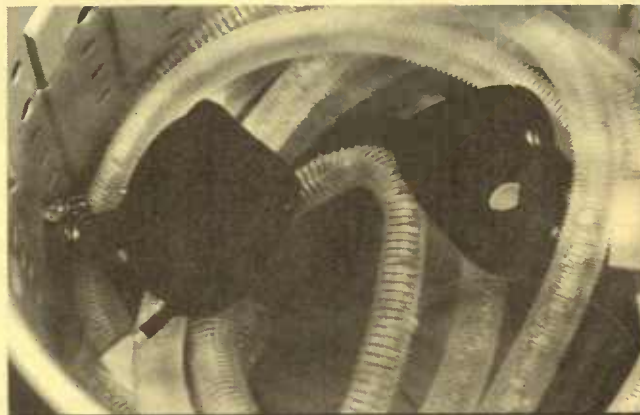
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Betty Lou Trimmer

For Canada's Indian and Inuit people, participating in their own destiny has for too long seemed like an impossible dream. Yet in health care, perhaps more than any other field, success will ultimately depend on their involvement. To encourage this, a new health worker has entered the arena — the Community Health Representative.

There is a saying that: "If you give a starving man a fish you've helped him for a day, but if you teach him how to fish you help him for a lifetime." For some native people, working on reserves across the country as health auxiliaries, this concept has special significance. These Community Health Representatives, as they are called, are part of a new thrust in health care to encourage self-help among Canada's native people. They are trained not only to give basic health care and health education to native communities, but to mobilize the people within the community to take an active role in determining their own health standards. They provide the spark that fires the enthusiasm of a whole community — to clean up garbage, to take responsibility for making improvements in sanitation and sewage disposal systems, to learn about maternal and child health care, to attend clinics ... They act as a liaison between nurses, doctors, environmental engineers and other experts, and their own people, whose problems they are in a unique position to understand.

The Community Health Representative Program, first instituted in 1961 by Health and Welfare Canada, has received a warm response from health professionals and native associations, and has expanded from a nucleus of 11 Community Health Representatives (CHRs) in Canada in 1961 to 488 in 1976. "These workers have the ears (and the hearts) of their own people. There is a willingness to act." As one chief said: "Why haven't we heard about germ theory before?" and he began to help organize his community to take steps to improve the sanitation facilities. A nurse commented: "I don't know what the Community Health Representative is saying, but I do know she trudges from home to home and now we get all the prenatals out to clinics, I am accepted more readily in the home and the use of our services has increased."

The Birth of an Idea

The concept of training and employing members of native communities in health

care is not new. In the early years, when Health and Welfare first took over native health, interpreters with on-the-job training were used to pass on health information. But new approaches to problems and different priorities required concentration on different aspects of health care. In 1943 the major health problems in Indian and Inuit communities were tuberculosis and communicable diseases, and priority was given to case detection, treatment and follow-up. The department concentrated on building hospitals, nursing stations and health centers, and on providing professionals to meet the most pressing health needs of the native people. In the late 1950s these efforts were rewarded by a dramatic decline in the TB death rate and a reduction in cases requiring hospitalization. Federally-run TB hospitals were converted to general hospitals for acute and chronic care, and some were closed in areas where municipal hospitals were large enough to serve the native population. In more isolated centers, nursing stations began

to play a more important role. Nurses located at these bases provided total service to the communities, seeking advice from doctors many miles away by telephone or radio, and when necessary, evacuating the very sick to treatment centers.

As the emphasis of health care shifted away from TB, other health problems began to surface. Pneumonia, gastrointestinal infections and accidents replaced TB as the leading causes of death. Focus began to switch to environmental hazards and communicable diseases. The living habits that suited the health and well-being of the native people when they were migratory were proving disastrously inadequate for community living. Adequate housing, safe water, sewage and garbage disposal became the new priorities, and it became clear that these changes required a more general approach than the treatment-oriented attack on tuberculosis. Nursing stations that were meant to serve several communities could not hope to reach each settlement with the necessary education, encouragement, support and care without additional help. The implementation of attitude and behavioral change in an area deeply rooted in the native culture would require more than just a medical approach. In fact it was doubtful that such a general change would be possible without the understanding, enthusiasm and initiative of the native communities themselves.

Faced with these considerations and keeping in mind the part native interpreters had played in the provision of health services in the past, the Health Educator for Health and Welfare, (MSB) Ethel Martens, proposed the "Community Health Worker" concept. This aimed at hiring mature members of native communities and training them to work in the community with the nurses, doctors and other experts and with their people.



Training

A pilot project was started to train native people as Community Health Workers in 1961. The first eleven students, chosen jointly by the native people and Health and Welfare, were selected more on the basis of their leadership abilities than their academic qualifications. Their education level ranged from six months to Grade 12.

Training was structured in three parts: a two-month orientation period in their home communities; a three-month workshop at Norway House, Manitoba, followed by continued on-the-job training in their home communities. The initial orientation was supervised by the field nurse and gave the student an opportunity to collect basic facts about their communities; learn the work of the teachers, RCMP, missionaries and other officials; find out what help is available for their people; and learn more about health conditions and some of their people's attitudes towards them. These assignments formed the basis for discussions during the three-month formal training.

The formal training period included instruction in basic health facts as well as First Aid training, nutrition, home nursing, teaching and communications skills, community organization, health promotion and treatment principles and methods. The course aimed to provide students with a total living-learning experience. They lived and grew together, spending some of the time in groups discussing their attitudes, perceptions of their new role in the community and their apprehensions about the future. Practical experience was stressed; students visited schools to teach nutrition and made trips to supermarkets to compare prices and make up a budget. The first training course proved very successful, in spite of some initial apprehension on the part of the students, and the one-year probationary period allowed time to sort out problems and refine the concept of community health auxiliaries.

Since 1961, basic education and training has changed somewhat but the orientation of the program remains much the same. The content of courses has evolved to further stress communication and community development. In-service education and further courses provide for the needs of individuals working in communities with specific problems.

One such course focuses on alcohol and drug abuse. As one CHR reported: "I found this program real interesting. I learned how to work as part of a group, how to be aware of problems, to give and take. What I found out was that you never do for an alcoholic what he could do for himself. We played roles of a counselor and an alcoholic, so that we would be aware of the problems we'd be getting into when we get back home to

our jobs. We also had to give a pitch on what our goals were going to be when we got home. My goal was to get more people to work with me, to see if anyone would come to me. Some came to me the first day I was home, asking for help. Talking to them was good 'cause I never got them mad. This is something that I'm really going to work on. I learned that you really have to get the person to trust you."

The Workers

Since the training of the first community health workers, the concept of community health auxiliaries in Canada's native communities mushroomed to the extent that by 1970 two new types of workers had been added to the ranks: the Community Health Aid and the Family Health Aid. In 1973 a Task Force reviewed the work of the community health auxiliaries and evaluated the direction the program was taking. As a result workers were amalgamated under the new heading of Community Health Representative. The report was very positive about the success of the program.² While health services to all communities under Medical Services Branch had improved throughout the years, it was noted that the benefits appeared to be more outstanding in areas with health auxiliaries than in those areas without their services.

Benefits from the CHR program include:

- increased demands for health services from the communities
- increased cooperation between native associations and Medical Services Branch
- development of health and allied committees to improve conditions in the community, create awareness of health and health needs and promote change
- community attention focused on related health needs such as housing, alcohol, educational opportunities, nutrition and community development
- decrease in infant mortality rates
- a reduction in the incidence of diarrhea, which used to alternate with pneumonia as the leading cause of death, to the extent that it is no longer in the top ten causes of death in the communities concerned
- a reduction in the incidence of tuberculosis to the point where it is rarely a cause of death
- a decreasing need for long-term hospitalization
- an immunization level in native communities which is now higher than in non-native communities
- a reduction in the incidence of lice, impetigo and otitis media
- an improvement in environmental conditions.

But the real story lies with the workers themselves. What do they do during a day or a month? What are their goals? What problems do they consider most pressing on their reserves? Do they like their jobs? Quotes from the monthly reports of some CHRs and from the answers to a questionnaire sent to CHRs in B.C. give insight into the program that does not appear in evaluations and reports.

One CHR described her job as follows: "My job as Community Health Representative is to home visit the community. I visit the chronically ill; assist the field nurse with the Child Health Clinic every week; assist with Doctor Health Clinic once a week held in Health Centre; interpret for non-English-speaking people who are unable to describe their illness sufficiently to the doctor or nurse during clinic visits; home visit the At-High-Risk infants; hold Brush-Ins teaching young children how to brush their teeth; show films on general health education, hygiene, cleanliness, birth dental program, family planning, sanitation clean-up, the importance of using garbage cans, how smoking can cause cancer, take water samples, make posters, assist in Ladies Cancer Clinic. Doctors call me once in a while if there is a problem they want me to follow up on a patient after discharge from hospital.

"I like this job, although it gets very hectic at times, but I've learned to be patient with people. What I find most interesting is what I've learned in just a couple of years. I learn as I go along with this job, new things that happen each day that I was never aware of before, I've even learned to communicate with my people better just by looking at the needs of the reserve. I've learned better communications just by looking and listening."



Monthly reports also give an idea of specific problems and how CHRs deal with them:

"Health is pretty good this month. Just a lot of people have to take TB pills. We were very busy this month. We had TB test and X-rays. We are having a hard time with one old man, has TB and he don't believe us, he says doctors are lying to him. We've done everything to make him take his pills. But he says we're trying to kill him with pills. He has active TB and there's about eight kids in the house.

"One man shot himself in the arm. He tried to commit suicide. They're going to send him down to treatment center. Too much drinking, as always, is the cause.

"Alcohol program — Sally and Harold are doing very well. They sent out three more persons to treatment center. I hope they'll stay there till they finish their treatment. I guess it's pretty hard for some people to stop drinking."

— *Helen Antoine, Necoslie*

"Met with Regional and Zone Nursing Officers. Took them to new Band office and school site. Had a very interesting chat with Regional Nursing Officer. Attended negotiation meeting in North Vancouver, very interesting.

"Had a class on VD for boys and girls. Showed films, had classes for girls on sex education and family life. Have no plans for July as people are busy moving around and some are working on fish. Also had discussions on dental health in school, showed films as well.

"We checked the stores and they were O.K. Visited infants, some of them are High Risk. Visited the old people who are chronic cases at least once a week because they are alone. The homemaker goes in and cleans house and

washes clothes for them, sometimes she cooks for some of them when there's no one around to do it."

— *Doris Tait, Aiyansh*

"Had two more days of dental this month. Did a Brush-in on 10 nursery and kindergarten children in the Health Station at Pavilion.

"Helped the nurse with a baby clinic in the Fountain Health Station, where we had a very good turnout. All babies under a year were brought in and all pre-schoolers were weighed. Same thing we do every month weather permitting. The nurse keeps all records. There were 26 children.

"The Salish Enterprise will be opening soon. The Chiefs plan an opening about the first part of April so there will be a laundromat in the community again.

"Spent a day putting videotape and monitor together. Something I was not taught, but managed to get it to work. Viewed tapes on nutrition and adolescence."

— *Georgina Redan, Cayoose Creek*

"We had a fairly good turnout at our Baby Clinic this month. Some of the older people still have chest colds. People seem to be drinking more booze this month for some reason. I notice this on my house visits.

"I brought a lady to the hospital for a gall bladder operation and stayed until she was all settled in. (I think she needed moral support). I talked to a young boy (a suicidal type) about drugs and dangers of alcohol. I talked to some members of my community about a one-day first aid course, there were a few people interested. I signed them up.

"I am attending a course in Vancouver, called the "Native Alcohol Abuse Program." I shall report on what we've covered in my next report."

— *Sarah D. Stewart, Lower Nicola*

"Meeting with Council and teachers about the poor rest and nutrition kids are getting — there will be monthly meetings with teachers. I now sit on the Education Committee.

"The Band is now in the process of hiring a garbage man.

"My one special project is to get an elderly lady to stop drinking, so I've gotten funds so she can teach tanning hides to younger people.

"I have noticed a change in the people, they are becoming aware of everything, a new feeling that I cannot describe."

— *Georgina Harry, Pavilion*

"... I have talked with the Chief about the many unfinished homes that people are moving into. He just seems to think it's up to each person. If that's the way they like it what can you do? I still

feel the Councillors have to see that these homes are complete before a family moves in.

"We've had quite a good turnout on our baby clinic days. Some of the mothers phone in to ask the nurse if their child needs a needle, but still there are always the same families who seem to think they are doing you a big favor if you get them to bring their kids in.

"Education "Career Day" held at the Noohath Hall with participation of ourselves and whole community for benefit of school children (a real good turnout).

"Alcohol abuse is still a big problem and children who are left alone. Head lice is another big problem, it seems we spend so many hours trying to help people you wonder if the time spent has been worthwhile. We have one lady on the TB pills. She was in a TB hospital last year for the second time yet she still doesn't seem to realize how important it is for her to take her pills each day not only for herself but for her family and friends too.

"I had sent water samples from some homes here. One report was unsatisfactory and I went to the home owner to tell the family to boil the drinking water because they have a lot of children. I went to Band office and they said they would take care of it, but to this day nothing has been done and I've gone twice since.

"Did a Pap-smear survey of women over the age of 18 with the help of the hospital staff. Out of 128 women, 78 had it done in this past year (which I feel is very good), rest done since 1970. We are trying to encourage ladies to have one this year.

"I try to make sure I get to visit our senior citizens since they always look forward to these visits. They cheer me up too when I get fed up with my job and make me feel needed and appreciated. They have learned many things in life and we can benefit from their wisdom.

"Young mothers just don't seem to realize the importance of getting their children immunized while still young no matter how many times we tell them, until something happens and they seem to think why wasn't I told?"

— Rose Hans, Bella Coola

Conclusion

The delivery of health care to the native people is an evolutionary process and the role of the CHR will continue to develop as new demands are placed on them. Their success to date underlines the philosophy that raising health standards means more than just launching an all-out attack on illness, or encouraging people to change their lifestyle. It means accepting Indians and Inuit as partners in determining their own health, in relying on their enthusiasm and initiative to improve community health standards.

The Community Health Representative has proven to be a valuable addition to the health care team, enabling us to take the first step in bringing health back to Canada's native people. ♣

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- 1 Martens, Ethel C., Community development — a health education technique, *Canad. J. Pub. Health*, 58:10, 454-456, Oct. 1967.
- 2 Health and Welfare Canada. *Community health auxiliaries: Report of the Task Force on Community Health Auxiliaries*, 1973, 190 pp.

Betty Lou Trimmer, the author of "Communication and Cooperation: a vital link" was recently appointed Indian Health Nursing Consultant in the Program Development Directorate at Medical Services Branch Headquarters. She is a graduate of the Regina General Hospital School of Nursing, holds a diploma in Public Health Nursing from the University of Saskatchewan, a B.S.N. from the University of Alberta and a M.P.H. from the University of Michigan. Trimmer has worked with Medical Services since 1967 gaining extensive experience as field, area, zone and regional Nursing Officer in Saskatchewan, Alberta and Pacific Regions.



Point of contact



Lucy Chapman
with
Elizabeth Roberts, M.D.

The Indian and Health program of the Medical Services Branch of Health and Welfare Canada covers a wide range of activities. Its focal points include: maternal and child health, communicable disease control, accidents and alcohol abuse, dental health treatment and prevention, health education and promotion. For administrative purposes, the program is organized on a regional basis that divides the country into nine regions: Yukon, Northwest Territories, Pacific, Alberta, Saskatchewan, Manitoba, Ontario, Quebec and Atlantic. Within these nine regions a total of 25 zones, each with its own professional, administrative, technical and operational staff have been designated. One of these zones is the Sioux Lookout Zone in northern Ontario where author Lucy Chapman provides the primary point of contact between the people in her community and the health care delivery team operating in the zone.

Background

The Sioux Lookout Zone covers an area of more than 100,000 square miles stretching from the Manitoba border on the west to the northern Ontario mining town of Hearst on the east. Its southern boundary is the transcontinental railway line that goes through the town of Sioux Lookout. On the north it borders Hudson's Bay.

There are 26 Indian reserves — Cree and Ojibway — located within the zone. The smallest of these contains only about 25 people; the largest has a population of about 1,200. Only seven of the reserves meet the population requirement that enables them to have a nursing station with resident nurses. The other 19 communities (approximately 45 per cent of the 8,400 native people living in this part of the Sioux Lookout Zone) rely on lay members of their community to provide their primary point of contact with the health care services in the zone.

Each nursing station has from two to four nurses working out of it when fully staffed. These nurses provide services for from one to six other communities (known as satellites) in addition to the community where the station is located. Nurses travel to these satellite communities every two weeks to hold clinics and to work with the lay representatives in the community. As often as possible, usually once a month, a general practitioner from Sioux Lookout accompanies the nurse on these visits. Sometimes the interval between visits from the general practitioner stretches to two or three months at a time. Certain features of life in these communities are common to all of them:

- Geographical isolation is a year-round problem.
- Only one of the 26 communities has an all-weather road system; the others rely on planes for food, mail and travel to points outside the immediate area.
- Small boats and snowmobiles provide transportation for short distances.
- The nearest hospital is more than 100 miles away from most reserves.
- Air travel is not only costly but also unpredictable because of the number of days when weather conditions make flying in or out impossible.
- Short wave radio is used for most communications although telephone systems are now being installed in some communities.

Sachigo Lake

Sachigo Lake where I work is a typical satellite community. Located 265 miles northeast of Sioux Lookout, and 96 miles from the closest nursing station, Sachigo is one of five satellites serviced by the four nurses at this station. Dentists and optometrists visit Sachigo annually;



Community Health Representatives from nine Sioux Lookout Zone reserves took time out from their one-week unofficial training session at Big Trout Lake nursing station to pose for this recent photograph.

nurses visit every two weeks and a doctor visits every two months. Usually the nurses and doctor stay overnight, but the rest of the time, I'm on my own.

I have worked as a lay dispenser or Community Health Representative for close to three years but was not officially employed until the early part of 1976. The first year and a half was especially difficult for me because in the beginning I had no formal training and I had to learn what was necessary from clinics held by

Another change that took getting used to was working with doctors and nurses. In the past, I had had no contact with them so I had to realize that they were human and answers weren't always at their fingertips. At Sachigo, the only form of communication is two-way radio. Even though there are three radios at our disposal, there are times when none of them work. In case of emergency, aircraft transportation is used but that, of course, depends on weather conditions.



Learning to listen to a chest is one of the skills CHR's picked up during a recent training sessions at Big Trout Lake nursing station.

nurses and doctors and from my own initiative. Perhaps one of the most important problems I faced was winning over the people's confidence — not easy when I didn't have much in myself. I also had to let the people understand early that I wasn't necessarily going to hand out drugs just because they asked for them.

Now, three years later, I still have a lot to learn but I have some solid experience behind me. I've had help from the people I work with and I'm more confident. I feel capable of handling most of the problems that are brought to the clinic, even if the radio does break down. In a week I see a lot of interesting people. These notes from my



CHR practices putting on a back slab, a useful first aid measure providing comfort for patients who may have to travel several hours by plane before reaching a hospital.



Anxious young patient waits his turn to be seen at the Angling Lake Clinic in the Sioux Lookout Zone.

Photos by Elizabeth Roberts, M.D.

diary may give you an idea of some of the work that I do.

June 26, 1978

One-year-old baby boy brought in with a heat rash and tonsillitis. Talked to the nurse to get advice since the boy had had a possible allergic reaction to penicillin in the past.

Forty-eight-year-old woman came in complaining of polyuria and flank pain. Urine testing with dipstick was positive. Treated with 222's* suggested that she increase fluid intake. A 'Uricult', (a urine collection that can indicate a urinary tract infection) was also taken.

Seven-month-old babe brought in with a diaper rash for quite a while now. Treated with *Mycostatin** cream and exposure of affected parts.

Twenty-seven-year-old woman complaining of vertigo, nausea and "feeling down." We chatted together for awhile and gave her *Gravol** to see if it would help.

Sixty-year-old man came in complaining of being itchy (scabies). Treated with *Kwellada*.* We talked about the benefits of showers if they were installed for community use.

June 27, 1978

Sixty-two-year-old with a chest infection came into the clinic. Treated as a bronchitis with antibiotics.

Ten-month-old baby with a chronic chest problem brought in by mother. I suggested she try chest physio. I demonstrated how to do it with the baby and also talked to her about the importance of providing humidity in the home.

One-year-old girl brought in with an upper respiratory infection. Treated with *ASA* and *Actified*.*

Fifteen-year-old girl came in with an injured hand due to a motor bike accident. Tensor bandage and arm elevated in a sling. Decided that there was no need for evacuation since the injury was very superficial.

Follow-up home visit done on the lady who came in with polyuria yesterday. Uricult turned out positive. Since she had had many urinary tract infections previously, I talked to one of the nurses before starting her on antibiotics.

I visited two fine old people today. The wife complained of an abdominal pain for which she usually took an antacid. The husband was down with a cold.

June 28, 1978

Thirty-year-old man came into the clinic today complaining of a persistent cough producing green sputum. Treated with an antibiotic; suggested humidity in the home along with chest physio.

A follow-up with the 27-year-old woman who came in yesterday with vertigo and nausea. Talked to the nurse about her but no treatment was given.

Seventeen-year-old boy, an epileptic, came in for his monthly drugs.

Forty-six-year-old woman came in with infected gums due to lack of dental hygiene. Stressed importance of using her toothbrush regularly. The mental health worker came into our community today especially to see a couple having marital problems. But she was available for anyone who wished to see her.

*Registered trademark.

June 29, 1978

Four-year-old boy with a chronic ear problem came in with otitis media. Talked to the nurse about whether he should be put on *Ampicillin** as it gets rather confusing when some people say "yes" and others say "no." He ended up with *Ampicillin*, ear hygiene and ear drops.

Fifty-year-old man came for his monthly drugs.

Follow-up done on the seven-month-old baby with the diaper rash. Suggested again to the mother to keep affected area clean and dry.

A home visit to the one-week-old baby who has a boil on his shoulder. Warm compresses today and follow-up tomorrow.

Home visit to an elderly lady who told me she has nits. Combed her hair with a fine tooth comb and will give her *Kwellada*.*

Took some medication that has recently arrived to a 66-year-old man diagnosed as having Parkinson's disease. Uneasy to use the medication without close medical supervision. Felt that the tremors were not bothering him all that much.

Twenty-seven-year-old fellow came in complaining about a headache. Treated with aspirin.

June 30, 1978

Follow-up home visit with a seven-month-old babe with a diaper rash. Mom noticed a greenish discharge from his penis. Mid-stream urine to be taken and urine collector to do a Uricult. Urine shipped off to Big Trout Nursing Station by next plane for the nurses to look at under a microscope.



Follow-up home visit to the one-week-old boy with the boil. Looks much improved.

One-year-old boy brought in with a laceration to his lip that happened yesterday.

A young woman came in for her birth control pills.

Yahoo! Long weekend coming up.

July 3, 1978

Ten-year-old girl fractured her arm this afternoon. Put on a splint and gave her a pain killer. Then escorted her to the the nursing station after arranging for transportation with the nurses. She had to go out further to Sioux Lookout and then on to Thunder Bay to have it fixed internally after reduction.

Holiday today! ☘

Author Lucy Chapman is a 24-year-old Cree Indian. Dr. Roberts told CNJ that Lucy may soon leave her position as CHR in Sachigo Lake so that she can prepare to enter a nursing program in Thunder Bay.

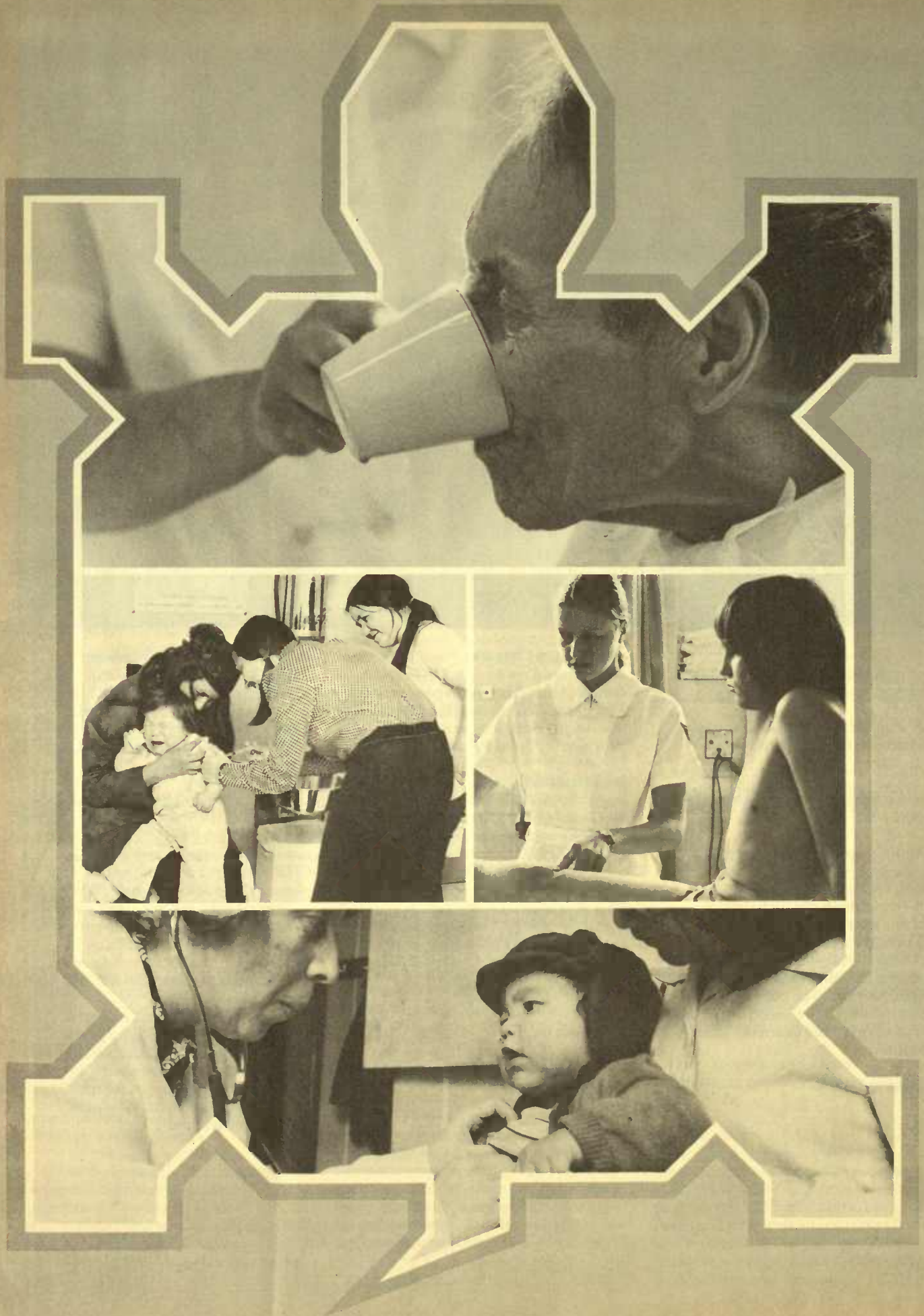
Dr. Elizabeth Roberts is presently employed as a Medical Consultant for the Grand Council Treaty Number Nine. She has worked in the Sioux Lookout Zone since 1973 — for three years as a General Practitioner with Health and Welfare Canada in Sioux Lookout and for one year as a private practice physician in Big Trout. Dr. Roberts received her medical degree from Saint Thomas Hospital in London, England.

Dr. Elizabeth Roberts comments:

"Lucy faces heavy responsibility as a CHR at Sachigo Lake. Most CHR's work in communities with a Public Health Nurse. Lucy does not — it is Lucy who sees the patients and Lucy who provides members of her community with primary care.

There is a problem in that there are only a few CHR's doing the kind of work that Lucy's job entails. These individuals need more extensive training than CHR's working in communities with nurses. I found, for example, that no one had taught the CHR's in this Zone how to take a patient history. The girls have picked up most of their skills by watching visiting doctors and nurses during clinics. I cannot believe this is a very efficient system.

When I realized that several of these CHR's had been working for years without attending a training session since 1970 or 1971, I arranged a week-long unofficial training session for them. I see this as a good argument in favor of inservice education."



Health in our time?

"We know from careful archeological research that up to the time of conquest the Indians of the Americas were remarkably free of disease. They enjoyed a general level of health far superior to that of their European conquerors. Their healers were skillful and successful, adept in surgical techniques and the use of herbal medicines, very sophisticated psychiatrists, knowledgeable geneticists. The hide tents, earth houses and plank homes of the people lacked flush toilets, hot and cold running water, and oil furnaces. They were often crowded. And yet, the people were superbly healthy. They had genuine community health."
(*A student of Indian history*)

"We are taking advantage of all possible methods of alleviating the situation — actual treatment, finding of disease, education ... We have had a constantly rising budget with which to perform this program. However, we believe we may now perhaps have arrived at the point where pouring a great deal more money into the health services side might not produce the results that we anticipate."

Until certain things happen on the socio-economic side ... until the effects of low income, poor living conditions, lack of access to services, poor communications — all the things that we take for granted in the country at large — have been improved, we wonder whether some of these dollars, instead of increasing the health budget, might not be diverted to these other problems."

(*The director general of the Medical Services Branch of Health and Welfare Canada in a brief presented to the Special Senate Committee on Poverty, Ottawa, 1970*).

"We had everything we needed on this island. That's why we survived. If there had been something missing we would have died off. But we were here, the strongest, most healthy people in the world — the North American Indians in 1492."

The white man tells us this is a modern world. You are modern people now; you have to drink Pepsi Cola now because that is the modern drink today. The only thing I see modern today is the deterioration of mankind."

(*Ernest Tootoosis in an address to members of the Registered Nurses of Canadian Indian Ancestry, Saskatoon, 1976*).

Otto Schaefer, M.D.

The last two centuries have not, in fact, been kind to Canada's native people in terms of their overall health picture. Following their first contact with groups of European immigrants, the previously isolated native population was swept by wave after wave of acute epidemics. Smallpox and measles decimated or completely wiped out many Indian tribes. Minor childhood diseases translated themselves into major killers among adults and children in the Canadian North. By the end of World War II, the death rate for tuberculosis among all residents of the N.W.T. had climbed to more than 700 per 100,000 of population. (See figure one) The total effect of all these chronic and acute infections was such that, during most of the 1930's and 40's, the death rate among the Inuit and Indians was higher than the birth rate. Since then the picture has changed drastically: improvements in health surveillance and in the health care delivery system have brought about sharply lower rates of mortality and morbidity for tuberculosis among northern natives. The gap between death and birth rates has been closed; the Inuit and Indians are no longer a disappearing people but rather the fastest growing ethnic group in North America.

"Progress" is not without its price however and recent years have seen a frightening increase in the diseases and deaths that can be directly linked to the social and cultural disintegration that has accompanied the changes taking place in the Canadian North. Accidents, violence and poisoning now rank as the leading causes of death among native people living in the Yukon and Northwest Territories. "Diseases of civilization"

Table I

Protein and fat content of commonly eaten meats
(gm/100 gm edible portion — uncooked)

ALASKAN ESKIMO DIET			UNITED STATES DIET		
Item	Protein	Fat	Item	Protein	Fat
Caribou	27	1.2	Veal side	19	12
Moose	26	1.1	Chicken	20	13
Seal	32	1.8	Pork side	12	45
Whale	24	0.7	Lamb side	16	28
Oogruk	27	0.4	Beef roast	17	23
Polar bear	26	3.1	Beef steak	16	25
Walrus	27	12.0	Hamburger	16	28
Whitefish*	25.8	1.3	Frankfurter	14	21

*(Trout and Char similar, dried fish has about twice the protein and fat content)

Note that in general game meat and fish are much richer in their nutritionally important protein content (almost double) while having much less potentially harmful fat interspersed in their muscle fibers than the meat of domesticated animals.

Source: J.C.D.A. Vol. 38, No. 1, Jan. 1977.

are beginning to appear — diseases such as obesity, gallstones, acne, diabetes, hypertension, atherosclerosis and phenomena such as changing fertility patterns, growth acceleration and even an increasing incidence of myopia. Abrupt and drastic changes in nutritional habits and nutritional status have been accompanied by remarkable differences in growth and development, dental and general health. In one trading district, for example, where it was possible to measure sugar consumption among the native population over an extended period of time, the amount of sugar consumed increased by 400 per cent over an eight-year period — from 26 pounds per capita in 1959 to 104.2 pounds in 1967. The effect of this dietary change, mostly in the form of "luxury sugars" such as candies, soft drinks, chocolates, etc. — in terms of dental health, obesity, acne, and anemia — is obvious to even the most casual observer.

The fight against TB

Tuberculosis, whose appearance in North America coincided with the arrival of the first large groups of European immigrants, found a virgin population with no specific immunity. A complicating factor was the low level of general resistance, a result of the waves of viral epidemics that had preceded the appearance of TB, disrupted nutritional patterns among the native population and the effects of alcohol consumption that were even then beginning to be felt. It is not surprising, therefore, that soon

after large scale contact between the European immigrants and the native people, more native Americans died than were born during any given period.

This situation persisted among the Indians and Inuit of the Northwest Territories until the late 1940's. The fact that the fight against TB was eventually successful is almost entirely due to the creation of an elaborate system of nursing stations in the North, supported by small but modern hospitals and staffed by Medical Services personnel employed by Health and Welfare Canada. It was nurses working in the field who intensified case finding through the medium of X-ray surveys, sputa examinations in adults and Mantoux testing in children. Evacuation to sanatoria, (between five and ten per cent of all Inuit seen during X-ray surveys

from 1955 to 1958, for example, were evacuated) treatment there and followup drug treatment in the home supervised by these nurses succeeded in bringing the TB epidemic under control.

By the early 1960's, deaths due to TB had been almost completely eliminated and both new infections and relapses in previously infected persons had been markedly reduced. Viral infections had also lost their deadly impact due to either rising immunity transmitted via placenta and mother-milk from mother to child or vaccination programs (smallpox, measles).

A new killer

Today, alcohol and VD have replaced tuberculosis and famine as the number one public health problems among Canada's native people. The incidence of

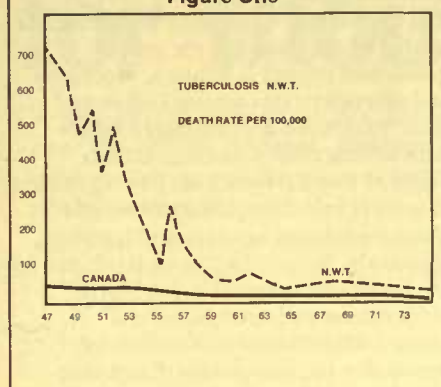
Table II

1964 daily per capita consumption of major nutrients in four Canadian Eskimo settlements
vs. 1955 U.S.A. consumption

	Total calories	Proteins (gms.)	Fat (gms.)	CHO (gms.)
Holman Island	2,859	280	79	230
Coppermine	2,536	271	64	213
Pangnirtung and Cumberland Sound	2,788	318	53	254
Frobisher Bay	2,097	128	57	254
Urban area, U.S.A. (1955)	3,200	103	155	275

Source: J.C.D.A. Vol. 38, No. 1, Jan. 1977.

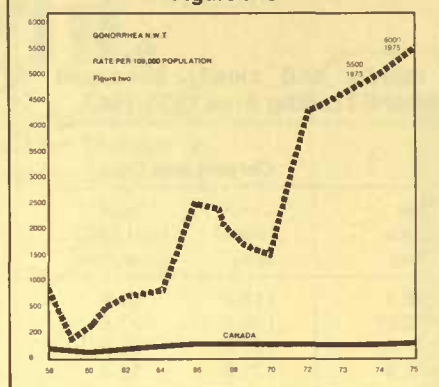
Figure One



gonorrhea in the Northwest Territories, for example, reached close to 4500 cases per 100,000 in 1972 as compared to approximately 750 cases ten years earlier. (See figure two)

In both the Northwest Territories and the Yukon, deaths due to violence and accidents, most of them directly related to alcohol abuse, have been the leading cause of death among the Indians and Inuit for the past ten years. The same is true for many Indian communities in other parts of Canada.

Figure two



Alcohol abuse is the direct or indirect cause of most of the sickness and suffering among these people. It is a major factor in hospital costs and the workload of all field staff. Its spinoff is seen in neglected and malnourished children, disturbed and consequently mentally ill adolescents from families of drinking parents. The overwhelming and truly genocidal role of alcohol in death and disease has been recognized by many outstanding native leaders who have spearheaded promising drives to

contain the problem and reverse the downward course of social, mental and physical health of their people by petitions and votes to enact local restrictions of alcohol availability.

Changing dietary patterns

Changes in lifestyle and diet among the Indians and Inuit have been less obvious to the general public. They have, nevertheless, been very profound and have had measureable effects on both the physical and social well-being of the entire population.

With the exception of the corn-growing Hurons and Iroquois of Southern Ontario and Quebec, Canadian Indians and Inuit used to live primarily by hunting and fishing; their diet consisted predominantly of protein. Since game meat and fish contain only a fraction of the fat and more protein than dairy products and meat from domesticated animals, (See table one) their diet was actually much lower in fat content than that of modern affluent peoples in Western nations. Table two shows average daily per capita consumption of the main nutrients in four representative Canadian Arctic trading districts for the year 1964. This was a period of transition for these communities and it is probable that fat consumption was lower in aboriginal times.

The diet of non-agricultural North American Indians and even more so that of the Inuit was very low in, but not completely devoid of, carbohydrates. These were available only in either a complex and slowly digestible and absorbable form (therefore not leading to sudden blood sugar peaks) — such as Glycogen contained in liver, heart and kidneys or Glyco-proteins in epitheliae of skin and gut, or in very limited amounts in berries, tubers, herbs and seaweeds gathered seasonally or consumed in partly digested form from the stomach and upper gut of caribou, moose, ptarmigan, hare, etc.

Table three shows the much higher Vitamin A and C content of such instinctively preferred and diligently collected native bush plants and berries, when compared with garden products which grow rapidly with the aid of artificial fertilizers, but are less rich in vitamins and minerals.

The trend to lesser protein intake with urbanization is obvious from table two. In 1964, the Inuit in Pangnirtung and Cumberland Sound still lived largely off the land and sea. Their protein intake

Table III

Comparison of commonly eaten domestic vegetables and fruits with edible greens from the James Bay Quebec area*

Garden vegetables	Per 100 grams	
	Vitamin A (I.U.)	Ascorbic acid (mg.)
Cabbage	130	51
Celery	240	9
Spinach	8,100	51
Green peppers	420	128
Peas (raw)	640	27
Carrots (raw)	11,000	8
Beets (boiled)	20	6
Potato (boiled, cooked)	trace	16
Tomato (raw)	900	23
Orange	200	50
Apple	90	4
Wild vegetables	Per 100 grams	
	Vitamin A (I.U.)	Ascorbic acid (mg.)
Bistort	—	158
Dandelion	800-14,000	30-66
Fireweed	18,708	220
Lyme grass	—	43
Mountain sorrel	8,900	40
Rose root	4,106	68
Lambs quarter	11,600	80
Scurvey grass	4,546	111
Sea purslane	5,753	42.5
Willow leaves	18,300	190
Violet leaves	8,258	210
Cloud berries	210-235	158-475

*From Report on the Waswanipi Cree, by C. S. Farkas

Table IV

Annual per capita consumption of rapidly and slowly absorbed carbohydrates in Pangnirtung, Cumberland Trading Area 1959-1967

Year	Sugar in all forms		Cereals and flour		
	per capita (lbs)	% of total CHO	per capita (lbs)	CHO content (lbs)*	% of total CHO consumed
1959	26	18.1	156.3	117.2	81.9
1960	37.6	22.4	173.5	130.1	77.6
1964	65.5	30.2	201.3	151.0	69.8
1967	104.2	44.2	175.9	131.9	55.8

*CHO content of cereals and flour varies somewhat but averages 75% which is taken here as basis for calculation.

In Canada (1960) 46.7% of calories derived from carbohydrates were consumed in form of sugar and sugar products.

In U.S.A. (Urban Household Consumers Survey 1955) 51%.

Source: J.C.D.A. Vol. 38, No. 1, Jan. 1977.

was almost three times that of natives in Frobisher Bay who were becoming more urbanized. With very few exceptions throughout the Arctic, protein intake has remained well above the recommended minimum requirements. Also, it should be noted that a mixed diet is not necessarily detrimental even to people who were formerly primarily meat consuming populations.

We are, however, definitely concerned with, and are seeing increasing evidence of, the harmful consequences of a trend to excessive consumption of rapidly absorbable carbohydrates — mainly sugar in all its forms. Table four shows what happened in Pangnirtung trading area between 1959 and 1967. Since then consumption in most places has increased by another 50 per cent. This phenomenal increase, particularly in the form of carbonated and non-carbonated sweet drinks which contain up to ten per cent sugar, candies, chocolates, sweet biscuits, etc. — often starts in infants as young as six months. It has affected the health and appearance of Indians and Inuit in many ways:

- In terms of dental health, the results have been obviously disastrous. Even though their parents and grandparents had or still have excellent teeth, worn down perhaps by hard chewing but firm and without caries, today's children have mouths that are graveyards of rotten stumps and young adults suffer from pyorrhea in prematurely receding gums.
- Excess caloric intake and decrease of physical activity has led to obesity, excess fat and cholesterol levels in blood

and tissues, gallbladder disease and adult-onset diabetes. These are all diseases typical of affluent Western societies. They were either absent or rare in traditional American natives but during the last generation have reached rates of prevalence in many North American Indian tribes far exceeding that in Whites. This process now appears to be affecting the Inuit in much the same way, particularly people living in the Western Arctic where changes in the way of living and eating occurred earlier than in the Central and Eastern Arctic.

- Marginal vitamin deficiencies, especially of Vitamins A and C, have become especially frequent in children and adolescents. Iron deficiency anemia, caused partly by the displacement of native food containing important minerals and vitamins by empty 'junk food', is another problem that is becoming rapidly apparent.
- Women of child-bearing age, whose requirements are higher, are also showing the early consequences of nutritional changes in the form of iron deficiency anemia and depletion of calcium stores. The latter problem is also becoming apparent among elderly Indians and Inuit who have not replaced their traditional sources of calcium and other minerals, obtained by chewing on the spongy parts of bones, with other sources such as milk, dairy products, cereals, etc.

The future

While the above examples show that all age groups have suffered in the course of

transition from traditional native nutrition habits, it should be stressed that the period of life when the mode and quality of nutrition has the most immediate impact is infancy. Morbidity and mortality rates among Indian and Inuit infants are demonstrably higher than among other Canadian infants. Some of this difference may be attributed to greater infection pressure brought about by inferior sanitary and housing standards. Some of it can be attributed to the harsh environment in the North. Under these circumstances, it is essential that the infant receive the protection transmitted by the mother through her breast milk and that the irritating or sensitizing factors of cow's milk or other foreign proteins be avoided.

Physicians making prenatal visits, hospital staff in maternity wards, but above all our field nurses on the reserves and in the North, influence the decision of native mothers about whether to breastfeed or bottle feed. Marked swings in the one or other direction observed following changes in personnel at various nursing stations attest to this.

The tremendous benefits of breast feeding — not just in terms of financial savings and workload reductions but also the health of our native patients — were clearly demonstrated in a recent survey in the Northwest Territories when we found much higher hospitalization rates among bottle-fed compared with breastfed infants in each of the ethnic subgroups examined. An enthusiastic nurse can make a positive contribution to the future health of her native patients by advising mothers of the proven superiority of this traditional feeding method over bottle and cereal feedings.

Otto Schaefer, MD, FRCP(C), is director of the Northern Medical Research Unit of Medical Services Branch, Northwest Territories Region, of Health and Welfare Canada. A graduate of the University of Heidelberg, he obtained his postgraduate training in Internal Medicine in Heidelberg, Baden-Baden and Freiburg (West Germany), before coming to Canada in 1951. He has been with the Medical Services Branch of Health and Welfare Canada since 1952 and has spent three two-year terms in each of the Western Arctic, Eastern Arctic and Yukon Territory Regions caring for Inuit and Indians as Medical Officer in the field. Dr. Schaefer is an honorary associate professor of medicine with the faculty of the University of Alberta.

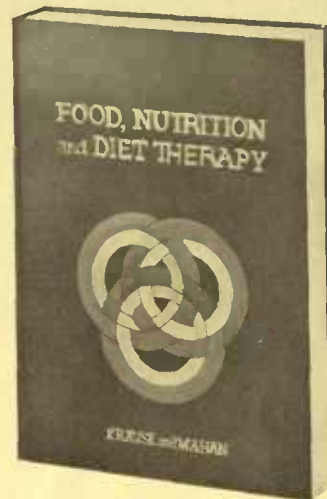
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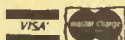
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Adoption or Assimilation?

Theresa Anderson-Courchene

Children of native ancestry, like children everywhere, hold the key to the future in their hands. They are the ones who must pass on the Indian cultural values and tribal traditions to the next generation. Today we are beginning to realize how valuable these traditions are in giving the Indian child a sense of identity and the richness of his past. For the Indian child who is taken out of his native environment and placed in a white foster or adoptive home, the transition often means loss of that identity.

In the province of Manitoba, there is increasing concern over the number of



native children under the care of the Children's Aid Society who are being placed in non-Indian homes. As an Indian who has lived in white foster homes, I know a little about this situation. Consider this: in 1976 the total population of Manitoba was 1,021,506. Of these, 979,195 were non-Indian while 42,311 were Registered Treaty Indians. More native children than non-native children are under the care of the Children's Aid Society.* However, there

* In 1977, approximately 110 native and 75 non-native children were in the care of the Children's Aid Society of Western Manitoba.

are many more non-Indian than Indian homes that the CAS considers suitable as foster homes. Therefore, the chances are great that the native child will be placed in a non-native home.

Any child placed in an unfamiliar situation experiences some degree of loneliness, desolation and isolation. Ask the parents of a child staying with a new babysitter. The native child in a white foster home, however, must deal, not just with a new family situation, but also with an unfamiliar culture. The foster family usually has different habits and behavior patterns and holds values contrary to traditional Indian values.

Cultural differences can inhibit the child and cause him to withdraw into a shell, thus damaging his relationships with the foster family and others in his peer group. Withdrawal can also be a factor in slowing down the child's learning process and if foster parents are

the other native children and adults. The child wishes to be able to identify with the native people, and yet there are strong ties with his foster parents.

I have already mentioned that there are few native foster homes available for child placement. Why is this? One reason is that all the potential foster homes are judged on the basis of white middle class values. Many native families do not meet these standards because of cultural differences — the native community holds values that white society does not. Often, native families in urban areas are expected to fit into the dominant ethics of white society. Certain characteristics of Indian culture, such as silence, modesty, non-aggressiveness, or non-materialism are regarded by non-Indians as problems to be overcome — not positive elements of a culture.

It would be better, I think, to place

The role of the nurse

In some communities, the nurse may be asked to accompany the social worker when a child is being brought into care. At this point, the first concern of the adults involved is meeting the child's basic needs — the need for food, shelter, and protection. But when will the far-ranging psychological needs of the child be considered? Should the nursing profession make a greater attempt to meet the cultural needs of children? Should nursing as a force be more involved in child welfare? I leave it to you to consider. ♡

Theresa Anderson-Courchene is an Ojibway Indian, born at Rolling River Indian Reserve, Manitoba. For seven years Theresa was a permanent ward under the Children's Aid Society. Presently she is majoring in history, minoring in native studies at the University of Manitoba.



All photos courtesy of Health and Welfare Canada.

not sensitive to these effects, the child may feel even more isolated.

People argue that after a short period of time, the child will adjust to his new environment. I am concerned however, that native children will be deprived of their cultural and traditional values because they have been uprooted from their Indian environment. Many Indian children experience the loss of natural parents and relatives, language, and traditional cultural values and beliefs which can lead to the loss of identity.

If non-Indian parents realize this and try to make the native child aware of his identity, both sides encounter difficulties. Parents attending traditional events find themselves outsiders, and have difficulty associating with the native people. Any child who is in this situation experiences emotional and psychological conflict. The foster parents appear physically different from

Indian children in an Indian community than in white foster homes because then the child would not have to readjust to a totally different environment. Granted, he would have to adjust to a new family but this is not as traumatic as the shift from a native family to white family. In the Indian community, the child could maintain his language, traditional customs and values and thus preserve a strong sense of identity as an Indian.

The cultural heritage and background of native persons is something to be cherished, respected and nurtured. It is rich in folklore, art forms and concepts of community life. But if Indian cultural heritage is to continue to grow and expand, further enriching the ethnic diversity of Canada, attitudes towards native peoples must change and Indian children must be given every opportunity to remain in their community.



Caring for Indian Outpatients

Pauline Steiman



My name is Pauline (Wood) Steiman. I am a licenced practical nurse currently taking courses towards my diploma in registered nursing. In addition to my night school courses, I work full-time at the Family Medical Centre Teaching Unit which is affiliated with the University of Manitoba, Northern Medical Unit, and St. Boniface General Hospital.

I am also a Cree Indian.

Because I am an Indian as well a nurse, I understand and appreciate Indian ways, customs and values. I know how happy my people were when they lived by themselves. Now we are being forced by circumstances beyond our control to live surrounded by non-Indians. We have had to adjust to a new setting, to doing things that "other people" do, to dressing and behaving like non-Indians. These are uncomfortable experiences for most of us and we have many problems in our day-to-day lives. One of these problems is related to the fact that we are now susceptible to all of the diseases that affect the rest of the population.

When native people visit city hospitals and clinics, they enter a whole new world. So many things in this new world are alien to our culture: cars, elevators, crowds and, most of all, the language, which many Indians still do not understand. What usually happens is that the nursing station nurse refers a native patient to a doctor at our clinic. If this request is approved by Indian Health Services, the person shows up at the clinic as an outpatient.

Many elderly patients do not approve of coming to the city to visit a doctor there. They attend the clinic or hospital only because the doctor has sent for them. When you ask them whether they agree to follow the treatment that the doctor prescribes, their comment is usually to the effect that "you are the doctor." Some old people have faith in the doctor as a "medicine person." For the Indian, this means more than just the treatment of disease and healing of injuries; it also includes religion. Indians make little distinction between medicine and religion since they consider the two to be closely interrelated.

Some natives, on the other hand, still prefer to put their faith in Indian medicine. They do not trust the medicine that the White man prescribes. One of my patients, an elderly lady who is a diabetic, is like this. She refused to administer her own insulin and said that



she would use Indian medicine instead. How would a non-Indian nurse react to this patient? Would she suspect voodoo? Would she call her patient uncooperative (or worse) or would she try to understand the reasons behind this old lady's refusal to accept the prescribed treatment? As an Indian nurse, at first I was startled by this patient's reaction. Then I started thinking about my own upbringing and I was forced to admit that I admired her honesty and respected her right to whatever beliefs she chose to accept. All I could do then was to try my best to teach this patient some of what I had learned about how the White man treated diabetes and hope that she would change her mind.

There are many ideas that are difficult for Indian patients to accept about health, illness, the treatment and prevention of disease. The pelvic examination procedure, for example, is not acceptable to most Indian women. Another elderly patient refused to use the toilet because she feared that she would contaminate it. She consented to use it only after a lengthy and detailed explanation in her own language.

Most of our expectant mothers do not make prenatal visits to the clinic until very late in their pregnancy, usually about 36 weeks. Often they are uncertain about the exact date when the baby is due. After their babies are born, they are usually anxious to return home as soon as possible because they have several other small children depending on them for their care. Since many of these infants are high-risk babies, the doctors would prefer to have the mothers remain under their care for a longer period.

Not so long ago, Indian babies were all born at home and it was an Indian grandmother or midwife who was in charge of the delivery. I recall one native girl whose baby was delivered by an Indian midwife. Because she was afraid

of complications, the nurse referred the infant to a doctor in the city and arranged for an ambulance to be on standby at the airport to transport the infant to the hospital. When they arrived, the attendants were appalled to discover the baby wrapped in a traditional moss bag. The doctor was not surprised and commented that it was the moss bag that had kept the baby alive by maintaining its body temperature while in transit.

There is a saying among our people that "a poor Indian is an Indian with no relatives." When Indian children come to city hospitals, the nurses observe that they are suffering from gastroenteritis, scabies, impetigo and lice. What they do not see are the conditions that account for these diseases — the fact that there is no running water, either hot or cold, in the homes and drinking water is often contaminated. They do not see the poor housing that gives the children pneumonia in the winter.

When these children come to the clinic, a non-Indian nurse is tempted to comment on how dirty they are. They do not stop to think that native people have to chop the wood to heat their homes, make a hole in the ice in winter for water and carry that pail of water a fair distance to the house in order to do any cooking or cleaning.

Sometimes native patients miss appointments or arrive late. It is easy to say that this happens because they are irresponsible or don't care. What we must do is try to understand the difficulties that they face in coping with strange surroundings and rigid schedules. We must make sure, also, that they go to the right clinic or hospital for their appointments when Medical Services has made arrangements for them to be seen.


A native nurse is really a split personality. As a nurse, she must try to explain to her people what she has learned and understands of the new scientific world. To do this successfully, she must also maintain her identity as an Indian, remembering and respecting the psychological influences, beliefs and customs of the native people.

Our people desperately need better health care and education. The nursing profession can help us to achieve this goal if only they will continue to develop expertise in learning about the Indian people and their needs in the home and in the community. ♣

Canada's "Barefoot" Midwives



The lives of northern Indian and Inuit people, whether in the Provinces, the Yukon or the Northwest Territories illustrate a conflict between old cultures and new technologies. Northern Canada is a vast land of legend, mystery, tundra plains and isolated communities. It is an enchanting, and at the same time, a frustrating land which has imposed a unique way of life on its inhabitants.



Canada's "Barefoot" Midwives

Cora L. Scott

It is in this harsh setting that we find a number of Canada's "barefoot" midwives. "Barefoot" not, of course, literally, but in the sense that they are native people (both men and women) who have preserved traditional beliefs, skills, attitudes, habits and customs. These midwives not only speak the community's language, they also know and understand ancient traditions that have been handed down from generation to generation. They are respected individuals and accorded an important social status within their communities.

For more than 4,000 years babies have been delivered by midwives who have developed their own system for dealing with their community's health care needs. The white man and his 'modern health services' came from the south only recently and with him came problems.

What happens when communities are exposed to modern health services when a majority of the population still relates to traditional methods and beliefs? A trained nurse from a different culture carries out health care with her own biases. It is particularly difficult to provide care to a population that is in a transition period from an old to a new culture. The nurse has to exercise considerable flexibility and humility when dealing with native patients.

Many pregnant native women want to have traditional midwives involved in the birth of their children. One major objection to the white man's way of delivery has to do with the positioning of the woman in the lithotomy and left lateral position. Native women do not understand this position. Whether we consider them right or wrong it is important for us, as nurses, to encourage native people in their desire to carry on with their traditional methods. Cooperation with native midwives is one step toward eventual harmony between the two cultures and can only bring about further cooperation, knowledge and the native people's self reliance.

The Inuit Delivery Process

1. A pregnant woman chooses two or three midwives several weeks or months before the delivery of her child. Sometimes the midwife she has chosen will have already delivered other children in this family.

2. As soon as labor starts, the house, igloo or tent is prepared for the birth. A place on the floor or ground is selected and cleared. Polar bear or caribou skins are laid down. If the delivery is taking place in an igloo and if twigs can be found then a mat made of twigs is prepared before the skins are laid. This is covered by a layer of plastic material (if it's available) and by layers of clothing and sheets to create a cushion on which the birth will take place.

3. As labor progresses the pregnant woman sits or kneels on the area with a midwife on either side of her. If there is a third midwife he or she sits behind the patient.

4. During contractions the woman kneels with her arms around the shoulders of each midwife. The third midwife supports the patient's back and helps to keep the woman upright.

5. Between contractions, the patient sinks back into the squatting position so that she is resting on her heels.

6. During the second stage of labor, the presenting part is rotated before contact is made with the cushion on which the mother is resting. In this way the presenting part slides gently to the cushion — the child does not 'fall' as is believed by those unacquainted with this method. The infant is resuscitated and wrapped in clothing, sheets or a fox skin and left to rest. The Inuit believe it is a bad omen to have prepared clothes for the infant before delivery. The mother stays in the same position for the delivery of the placenta.

I have watched many Inuit women through their traditional birthing process. The deliveries were calm and did not require my intervention. The patient had control over herself and the delivery.

While serving as an outpost nurse in isolated native communities I feel I have been privileged to work with Indian and Inuit midwives. Their practical methods have served a people living a nomadic life in tents and igloos well and they can still work if given a chance within modern health services. A good working relationship with these midwives can foster an appreciation of their traditional skills and beliefs and help us in the process of cross-cultural nursing. ♣

Cora L. Scott, the author of "Canada's Barefoot Midwives," was educated in Jamaica, England, Wales and Canada. Right now she is working among this country's native people as a Zone Nursing Officer with Medical Services, Health and Welfare Canada.

Indian nurses face the challenge

Photo courtesy of Health and Welfare Canada.



It was at the end of August, 1975, during International Women's Year, that 43 nurses of Canadian Indian ancestry assembled in Montreal to explore the issues surrounding Indian health. This meeting of the Registered Nurses of Canadian Indian Ancestry marked the first time in history that professionals of native ancestry in Canada gathered for a national assembly.

The idea of forming an Indian Nurses Association was conceived in 1974 by a few nurses who were concerned about the poor health of their people as a group. They felt that Indian nurses acting collectively could do a great deal to influence the health of their people.

The August 1975 meeting set the idea in motion. Discussion at this time centered on questions such as the role of Indian health professionals as a force in the improvement of Indian health, and the role of the Indian nurse in encouraging more native people to enter the health professions.

During the meeting, the following objectives were developed and adopted for the Registered Nurses Association of Canadian Indian Ancestry:

- To act as an agent in promoting and striving for better health for the Indian

people, that is, a state of complete physical, mental, social, and spiritual well-being.

- To conduct studies and maintain reporting, compiling information and publishing of material on Indian health, medicine and culture.
- To offer assistance to government and private agencies in developing programs designed to improve health in Indian communities.
- To maintain a consultative mechanism whereby the association, bands and government agencies and other agencies concerned with Indian health may utilize.
- To develop and encourage courses in the educational system and nursing and health professions on Indian health and cross-cultural nursing.
- To develop general awareness of Indian and non-Indian communities of the special health needs of Indian people.
- To generally encourage and facilitate Indian control of Indian health, involvement, and decision-making in

Indian health care.

- To research cross-cultural nursing and cross-cultural medicine and develop and assemble material on Indian health.
- To actively develop a means of recruiting more people of Indian ancestry into the medical field and health professions.
- To generally develop and maintain on an on-going basis, a registry of Registered Nurses of Canadian Indian Ancestry.

These objectives reflect the strong interest of the association in becoming involved in the services available to the Indian people. What steps has the association taken since that first meeting to realize its aims?

Progress in meeting the stated objectives has been greatly impeded by lack of funds on a national level. Although the national association has applied for funds from the various government departments responsible for Indian programs, these attempts to secure funding have not been successful.

Jean Goodwill, who was one of the organizers of R.N.C.I.A., says that although funds are not forthcoming on a national level, the interest of Indian

nurses in the national association is still very much alive. She added that national meetings are of great importance in maintaining the interest of members in the goals of the Registered Nurses of Canadian Indian Ancestry.

Within the national association, the Manitoba group has been most active in pursuing the objectives of the association, by assisting in the development of the organization itself and of the registry. The activities of this group are summarized by two student nurses who have been active members of their association ...

The Manitoba group

In Manitoba, we have been involved in committees that work with agencies to promote better health training in the province, specifically through the "On-Reserve Registered Nurses Training Program". This involvement has proven a worthwhile experience, both for the agencies and nurses involved in debates about curriculum, theory and experience. So far, a "nurse developer" position has been made available at Keewatin Community College in The Pas for this project.

How were we to begin to exchange information and ideas with nurses, Indian Bands and those interested in Indian health? The publication of a newsletter seemed like a good idea. With the assistance of two Indian student nurses, the organization developed a newsletter, a unique Indian paper in many ways. According to one of those responsible for the newsletter, "We put out a paper whenever we have a lot to say". Last year, there were two papers; this year, three. The newsletter is supported by funds raised through raffles and archery contests.

Information-sharing has also been encouraged in seminars sponsored by the Manitoba group. We have held two seminars on Indian health so far: the first in The Pas in 1976; the second in Brandon at the Brandon General Hospital in November, 1977.

The Manitoba group of the R.N.C.I.A. is an official interest group of the Manitoba Association of Registered Nurses. This status enabled us to participate in round-table discussions at MARN's annual meeting in 1977. Several of our nurses were also able to attend The American Indian Nurses Conference held in Yakima, Washington in June of 1978. The Canadian delegation was met with enthusiasm. Many ideas were exchanged at the meeting, including the possibility of some relationship with the American Indian Nurses Association.

More recently, two students were hired by our group as part of a summer project funded by the Secretary of State, in order to pursue the objectives of the R.N.C.I.A. more actively. We have been able to raise funds by means of a bazaar and a raffle, and hope to use the money to purchase audiovisual equipment, tapes and books as a foundation for the development of an Indian Nursing Resource Library.

The students have been able to help in other ways as well. With the Manitoba Association of Registered Nurses, they have participated in "Career Day" at Fort Alexander High School, to assist high school students to become aware of the opportunities available in the health care field.

Other Indian organizations have shown considerable interest and cooperation with our group. They have been most supportive of the group's efforts to organize and bring together the knowledge of the Indian people, Indian medicine and the medicine of the modern world.

Since the beginning of our association, Ernie Tootoosis has acted as our elder. A nationally known and respected medicine man and spiritual advisor, he is from the Poundmaker Reserve in Saskatchewan. He sees no reason why we cannot also be medicine women, spiritual leaders and professionals in hospitals, and has provided guidance to our group in Indian medicine.

The Canadian Lung Association requested input from our group for a conference this year. We have learned a great deal about finding and analyzing data in preparation for a presentation at their annual conference in Winnipeg.

At the present time, we are investigating the area of violent deaths and the Indian people. This topic is very broad in scope and covers areas such as death by fire, drowning, exposure, suicide and motor vehicle accidents. We are attempting to look at these different areas from many perspectives. The Indian nurses who work in nursing stations in northern Manitoba are studying the subject from their point of view, and hospital nurses will be contributing as well. We foresee that this particular project will take a good deal of exploring — through libraries, specific articles, and conversations with people. It is hoped that our investigation will be finished within one year.

The Indian nurses of Manitoba have been very interested and active in their dedication to the objectives drawn up by the national association in August of 1975. We are now looking forward to a national conference within the coming year. ♣

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Indications: Santyl Ointment is indicated for debriding dermal ulcers and severely burned areas.

Contraindications: Application is contraindicated in patients who have shown local or systemic hypersensitivity to Collagenase.

Precautions: The enzyme's optimal pH range is 7 to 8. Lower pH conditions have a definite adverse effect on the enzyme's activity, and appropriate precautions should be taken.

The enzymatic activity is also adversely affected by detergents and hexachlorophene and heavy metal ions such as mercury and silver which are used in some antiseptics. When it is suspected such materials have been used, the site should be carefully cleansed by repeated washings with normal saline before Santyl Ointment is applied. Soaks containing metal ions or acidic solutions such as Burrow's solution should be avoided because of the metal ion and low pH. Cleansing materials such as hydrogen peroxide or Dakin's solution do not interfere with the activity of the enzyme.

Debrided patients should be closely monitored for systemic bacterial infections because of the theoretical possibility that debriding enzymes may increase the risk of bacteremia.

The ointment should be confined to the area of the lesion in order to avoid the risk of irritation or maceration of normal skin.

A slight erythema has been noted occasionally in the surrounding tissue particularly when the enzyme ointment was not confined to the lesion. This can be readily controlled by protecting the healthy skin with a material such as Lassar's paste.

Since the enzyme is a protein, sensitization may develop with prolonged use although none has been observed to date.

Adverse Reactions: Adverse reactions to Collagenase have not been noted when used as directed.

Dosage & Administration: Santyl Ointment should be applied once daily (or once every other day in the case of outpatients) in the following manner:

- (1) Prior to application the lesions should be gently cleansed with a gauze pad saturated in normal saline, buffer (pH 7.0-7.5) or hydrogen peroxide to remove any film and digested material.
- (2) Whenever infection is present, as evidenced by positive cultures, pus, inflammation or odor, it is desirable to use an appropriate topical antibacterial agent. Neomycin-Bacitracin-Polymyxin B (Neosporin) has been found compatible with Santyl ointment. This antibiotic should be applied to the lesion in powder form or solution prior to the application of Santyl ointment. Should the infection not respond, therapy with Santyl ointment should be discontinued until remission of the infection.
- (3) Santyl ointment should be applied (using a wooden or plastic tongue depressor or spatula) directly to deep wounds, or, when dealing with shallow wounds, to a sterile gauze pad which is then applied to the wound. The wound is covered with sterile gauze pad and secured with clear tape or Kling bandage.
- (4) Crosshatching thick eschar with a #10 blade is helpful. It is also desirable to remove as much loosened detritus as can be done readily with forceps and scissors.
- (5) All excess ointment should be removed each time dressing is changed.
- (6) Use of the ointment should be terminated when sufficient debridement of necrotic tissue has taken place.

Overdose: Action of the enzyme may be stopped, should this be desired, by the application of Burrow's solution U.S.P. (pH 3.6-4.4) to the lesion.

How Supplied: Available in 25 gram jar of sterile ointment. Product monograph available on request. Store at room temperature.

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(Varma, Bugatch & German, Surgery, Feb. 1973)

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— W. E. Zimmermann, Mod. Med. (U.S.A.), Apr. 1970

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(M. Murray Nierman, "Cutis", Oct. 1976)

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(Helga Vetra, Derrick Whittaker, Geriatrics, Aug. 1975)

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Home nursing for northerners



Michael J. Hewitt

Flying through blowing snow in failing light over the Arctic tundra is an experience I am quite willing to live without. Like many northern nurses, however, I have had to do it on many occasions when emergency "medivacs" were required. On one notable medivac, we ran into patches of fog and were forced to fly very low while searching for the Inuit camp we were trying to reach. Our single engine aircraft was equipped with pontoons, so the rocky ground — so close at hand — looked even more uninviting than usual.

We eventually landed on the Arctic Ocean in a style reminiscent of that of a moulting duck. It seemed we had picked up some ice on our wings during the flight — not a good omen for the return ...

On a small desolate island, two small canvas tents huddled alongside a pile of huge shattered boulders. The late fall wind moaned across the sea, smashing the waves

against ice-covered rocks. At first sight, I felt that it was no place to live and certainly not the spot to be ill.

Of the ten Inuit in the camp (two families), two were ill. One man was recovering from an upper respiratory infection, and the other, the wife of the only other man in the group, had an infection of unknown origin on the left side of her face.

The entire left side of her face was grossly swollen from the eyebrow to the angle of her jaw, and all that could be seen of her eye was a purulent crease in her skin. All I could do under the circumstances was give her medication for pain, which must have been considerable (although the woman did not complain), and transport her to hospital some 350 miles away.

Our return trip was somewhat easier — we climbed through the fog and low cloud and flew straight to Yellowknife. The treatment of our passenger revealed that

the cause of her illness was a small sore adjacent to her eye — probably a black fly bite originally — that had become infected, and untreated, developed into a serious condition.

Fortunately, the woman's sight was saved and she recovered completely, but it seemed to me at the time (and my conviction has now strengthened considerably) that some knowledge of basic nursing skills might well have prevented the situation from developing as it did.

Nurses throughout the Canadian north who work in nursing stations know only too well the difference that early diagnosis and treatment can make in the lives of isolated people. A knowledge of how to prevent illness, infection and accidents is as valuable to people living in isolation as the corner drug store is to the city dweller — perhaps even more so.



Many people still make their living on the land in the Northwest Territories, a vast, lonely and beautiful land with ever-distant horizons. For many residents of the NWT, hospitalization is not the relatively simple matter that it is for those in southern Canada. Most people are apprehensive about entering a hospital, and for a great number of northern residents, this fear is compounded by a

language barrier and by the fact that the hospital may be hundreds of miles from home, family and friends. It is obvious to the most casual observer that admission to a hospital or nursing station is a very costly matter, both in financial and in human terms.

It is in this context that the NWT Council of St. John Ambulance has developed its first aid and home nursing programs, both in multilingual format. The NWT St. John Home Nursing Program has been reviewed and approved by nurses and doctors in both northern and southern Canada. Equally enthusiastic are the native people who helped produce the course and those who have received the training it offers.

For the past two years, the NWT Council of St. John has offered a home nursing course with the following primary aims:

- a reduction in the number of admissions to a hospital or nursing station;
- a reduction in the length of stay, should hospitalization be necessary;
- a reduction in the workload at northern nursing stations and hospitals;
- a reduction in the trauma produced by prolonged family separation.

These objectives can be met to some degree if someone in the family has home nursing skills. Should the patient be hospitalized, early discharge is often possible if there is a person at home trained to take care of him, a fact much appreciated by the hard-working nurses in northern Canada's nursing stations.

The program developed by the NWT Council is based on the St. John Ambulance home nursing course, with special adaptations to the northern environment. The sound-on-slide production has a sound track produced in several native languages.

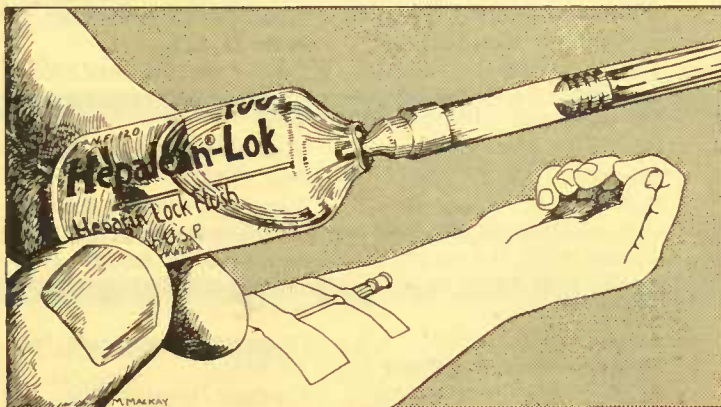
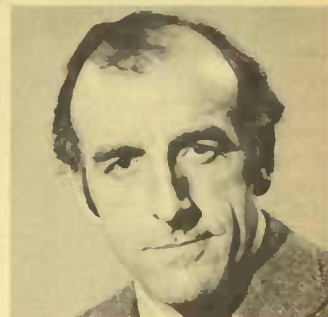
During the summer of 1976, the entire program was reviewed and revised through a contract with Medical Services. Experiences in the winter of 1977 pointed out the need for some changes and additions, all of which have now been made. With the help of staff from the NWT government safety division,

the local press and the CBC, all most willingly given, we have produced a 21-hour course which includes northern water safety, gun safety and safety in the home.

The stars of the AV production are native people from various parts of the NWT. Their wholehearted cooperation has confirmed the value of the program and their input was invaluable in tailoring the program to meet northern needs. The revised program is being translated into three Inuit dialects and two Indian languages by the Interpreter corps of the NWT government.

Since 1975, Michael J. Hewitt (R.N., Registered Psychiatric Nurse, U.K.; P.H.N., Dalhousie University, Halifax, Nova Scotia) has been Executive Director, NWT Council of St. John. Prior to this appointment, he has had experience in various parts of northern Canada. In 1963, he was appointed Nurse-in-Charge, Fort à la Corne Nursing Station, Saskatchewan, and then he was transferred to Yellowknife, N.W.T., where he worked for 12 1/2 years as Nurse-in-Charge, Health Centre, Zone Nursing Officer,

Mackenzie Zone, and Assistant Zone Director, Baffin Zone.



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Calendar

October

Nursing education programs offered at the University of Alberta, Edmonton:
Anatomy and physiology review for nurses, Oct. 10, \$35.
Quality Assurance, Oct. 12-13, \$40.
Gynecology, obstetrics, pediatrics, Oct. 23-25, \$60.
Writing skills for nurses, Oct. 16-17, \$60.
Instructional skills for nurses, Nov. 1-2, \$45.
Staffing for patient care, Nov. 16-17, \$60.
Mental health in work settings, Nov. 30-Dec. 1, \$40.
Self-care framework as applied to health care practice, Dec. 13, \$30.
 Self study programs in nursing

on a variety of topics are also available for both individuals and groups.
 Contact: *Millie Pasemko, Faculty of Extension, The University of Alberta, Corbett Hall, Edmonton, Alta. T6G 2G4.*

Association of Registered Nurses of Newfoundland Twenty Fourth Annual Meeting to be held on Oct. 23-25, 1978 at the Holiday Inn, St. John's, Newfoundland.
 Contact: *ARNN, 67 LeMarchant Road, St. John's, Newfoundland, A1C 6A1.*

Nurse Practitioners Association of Ontario, one day conference to be held at the Ramada Inn (Airport

west), in Toronto on Oct. 28, 1978. Guest speaker: *Mary Vachon*. Contact: *Johanna Mousseau, 366 John St. S., 8, Hamilton, Ontario, L8N 2E4.*

Gerontological Nursing Association Conference 1978 to be held at Hotel Plaza II in Toronto on Oct. 27, 1978. Theme: Cardiovascular status in aging. Contact: *Marie Hannum, Gerontological Nursing Association, 20 Godstone Rd., Suite 211, Willowdale, Ontario, M2J 3C5.*

November

Second International Seminar on Terminal Care. "A forum for the discussion of Critical Issues in the Care of Dying Persons and Their Families". To be held on Nov. 2-4, 1978 at the Queen Elizabeth Hotel, Montreal. Fee: \$150. Visiting faculty includes Cicely Saunders. Contact: *The Post-Graduate Board, Royal Victoria Hospital, 687 Pine Avenue West, Montreal, Quebec H3A 1A1.*

Annual Seminar of the Manitoba Operating Room Nurses Study Group will be held in conjunction with the Manitoba Health Organization Conference on Nov. 2, 1978. Contact: *Ellen Spencer, Operating Room General Centre, 700 William Ave., Winnipeg, Man. R3E 0W1.*

National Organization and Conference on Geriatrics. To be held in Ottawa on Nov. 16-17, 1978. Contact: *Marg Lewis, Conference Co-ordinator, c/o Oscarfield Management, 1339 Baseline Rd., Suite 5708, Ottawa, Ont.*

Canadian Intravenous Nurses Association Third Annual Convention. To be held at the Inn on the Park, Toronto, Ont. on Nov. 22-23, 1978.

Contact: *CINA, 20 Wynford Drive, Suite 216, Don Mills, Ont.*

Critical Care 1978. Oxygen and chemical balance in the critically ill. To be held on Nov. 19-20 or Nov. 21-22, in Toronto, Ont. Fee: \$60. Contact: *Marina Heidman, Continuing Education Coordinator for Nursing, Health Sciences Division, Humber College, Box 1900, Rexdale, Ontario, M9W 5L7.*

Continuing Education Programs offered at the University of Toronto:
Stress relieving strategies: nursing in management positions, Nov. 16, \$25.
Stress relieving strategies: nursing in staff positions, Nov. 23, \$25.
Care of the disturbed elderly patient, Nov. 31 and Dec. 1, \$50.
Evaluations are for growing, Dec. 7, \$25.
Nursing process in mental health and psychiatric nursing, Nov. 1-3, \$75.
Pain: a nursing concern, Nov. 9, \$25.
Gynecology for nurses, Nov. 14, \$25.
 Contact: *Dorothy Miles, Director, Continuing Education Program, University of Toronto, Faculty of Nursing, 50 St. George St., Toronto, Ont.*

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A certificate program in gerontology has been instituted at the University of Manitoba. The two-year program beginning this fall is for anyone working in the field of gerontology. Interested persons should contact the Continuing Education Division, The University of Manitoba, Winnipeg, Manitoba, R3T 2N2.

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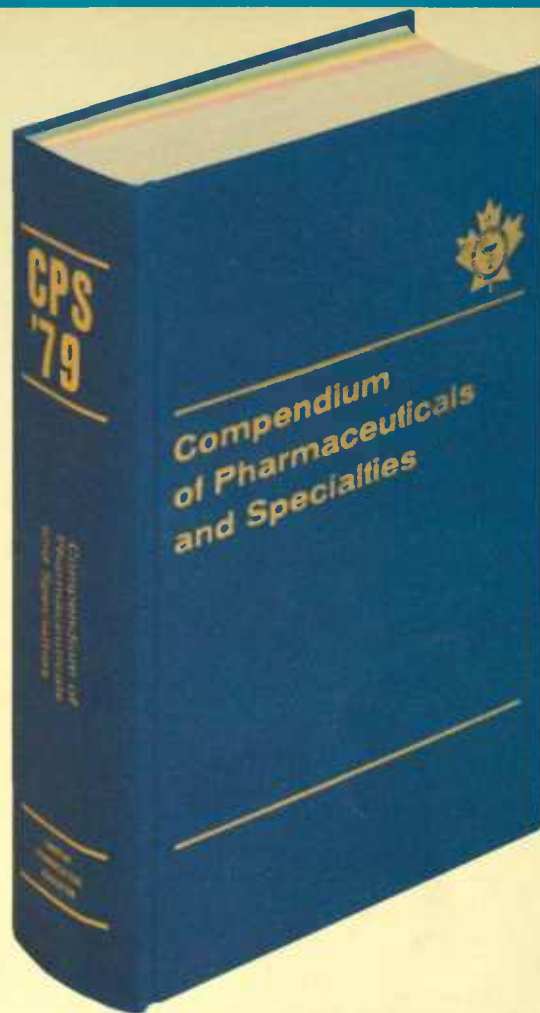
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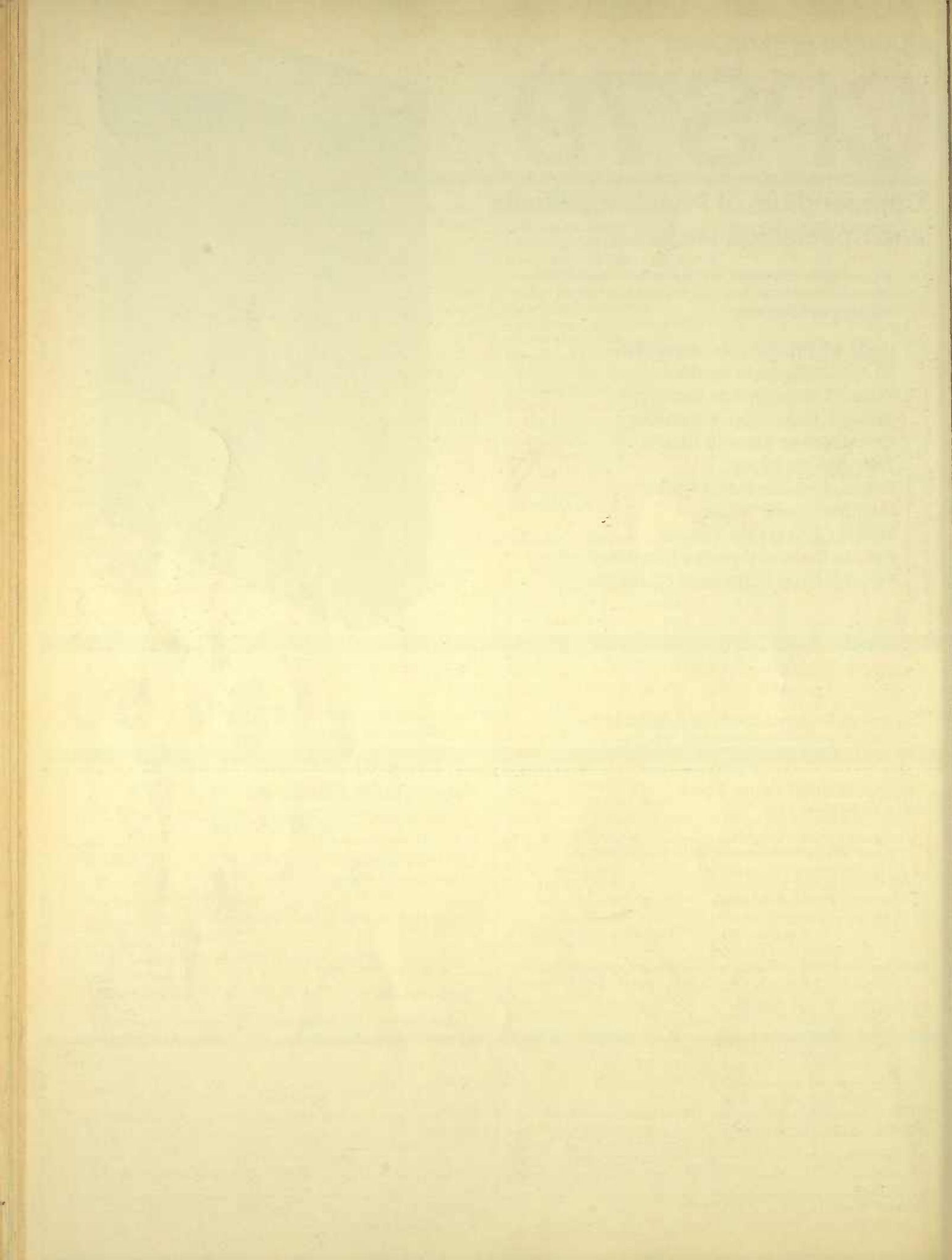
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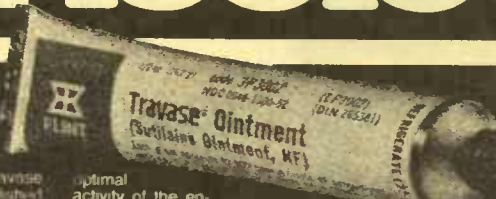
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CNJ talks to ... Janet Powell, CHR



CNJ: *I understand that you are a community health representative employed by Health and Welfare Canada. Where is it that you work?*

POWELL: I live and work on Tulsquate reserve in B.C., on the northern tip of Vancouver Island.

CNJ: *Can you describe your clients?*

POWELL: There are about 255 Indians on the reserve — 240 Band members and 15 non-Band members. Some of the men work at logging or, in the summer, salmon fishing, but this only lasts for three months at the most each year.

Occasionally, both men and women get jobs loading pulp ships at Port Alice — 43 miles away by road and, sometimes, some of the ladies work at the local fish cannery.

CNJ: *How long have you been a CHR and what sort of training did you have before you began this work?*

POWELL: First, I was trained by a health educator from Medical Services (Health and Welfare Canada). Then three years ago I qualified in Home Nursing and got my first certificate in Emergency First Aid. This past year I took my exams and qualified in Standard First Aid.

CNJ: *What does your job entail?*

POWELL: I do so many things ... but mostly, I make home visits to people on this reserve including the chronically ill and high-risk infants. I help the field nurse every week at child health clinic; I help the doctor at the clinic at the Health Centre. At these clinics I interpret for people who don't speak enough English to describe their illness to the doctor or nurse. I hold Brush-Ins to teach the children how to brush their teeth and I show films on health education — hygiene, family planning, birth, dental care. I teach people about sanitation — the importance of garbage bins — how smoking can cause cancer.

I make posters, take water samples and help at the Ladies' Cancer Clinic.

CNJ: *What are the main problems that you see in your community and what are you trying to do about them?*

POWELL: In this community there are three main problems: alcoholism, poor housing and overcrowding, and unemployment.

I try to assist the people in every way I can to better their health, stressing what alcohol does to a person physically, poverty and everything that goes with it. I try to get this across so that the individual can say, "Okay, I need help."

I find time to visit the Chief at home to talk to him about the problems of the Band. I visit with the Band manager and discuss how we can improve the community. I complain so much ... and I'll keep complaining to the Chief and the councillors.

If a person is looking for work, I tell him "Go to Manpower every day. Pretty soon they'll get tired of you and put you to work." Hopefully, this is what happens occasionally.

Janet Powell, like other CHR's, submits a monthly report to the health educator in charge of Medical Services in her province. These reports are compiled and circulated among the CHR's. Here are some excerpts from the reports that Janet submitted last summer.

August 2 — Today was a bad start for me. I left home and started up at Hospital. Checked with the Health Center to see who was in during weekend. I got a report that a young mother gave birth yesterday evening to her first baby. This girl we gave all the best prenatal care to during her pregnancy, but towards the last week she started drinking heavily, tripped and fell, too drunk to realize she injured the unborn child in her stomach. The baby born to her died seven hours later. It's a sad, sad experience. Doctor ordered an autopsy.

Received a phone call at home concerning an accident. A young mother riding a bike while she was under the influence of alcohol. Broke her leg. She had to be flown to Vancouver General Hospital, escorted by another person. Children placed in Receiving Home. She has three very young babies.

August 8 — Attended a Band Meeting today because I was invited. Sorry I went. I hardly think I'll accept an invitation to attend Band Meetings again. Very poor communications. I was completely ignored. In fact one man said I had no business to be there and if I had any complaints to forward them in writing.

August 15 — Another attempted suicide — man missed, shot a bullet through the ceiling of his home. I often wonder is this all worth it? I almost feel I am not accomplishing anything in this job as CHR for this reserve. *But I guess we all feel like this at times?*

August 24 — I went to pick up two babies for C.H.C. While I waited, a woman appeared unexpectedly beside me. I had my car door open because I wanted to be ready to offer my help because it was raining heavily. When this woman asked me to drive her to Port Hardy, I told her I was very busy — I only had one hour left to pick up all the babies that had to get checked — some to get immunized. She got very violent, pulled me out of my car. I had to defend myself. I grabbed her by her jacket and pushed hard as I could. I told her I was not afraid of her, although I was very afraid. She called me all sorts of names and threatened me. She was going for help. I hollered at the young mother to hurry and get in my car. The woman kept chucking rocks at my car. I quickly drove up to the Receiving Home, dropped off mother and her baby and niece then went home and phoned PHN, and told her I will not be able to return this young woman and children to their home, afraid this woman would attack me again. *This day I almost packed up off my job.*

September 1 — I will have one less chronic patient. She passed away 10:00 a.m. this morning. The doctors and nurses did all they could to try to save her life but she hemorrhaged to death. Survived by her husband, five daughters, three sons and three grandchildren. Burial will take place in Alert Bay Cemetery. *I hope nobody else has as many problems as I have had this month of August.*

September 7 — Public Health Nurse of Alert Bay and CHR Dorothy Alfred, also of Alert Bay, visited us today. Ruth Elvey, psychologist of our Medical Services also visiting. We discussed mental health, (mostly suicide cases), of this end of Island. Didn't really realize it's climbed so high until I saw the statistics.

September 13 — Knocked on every door this morning handing out notices about films on cancer to be shown tonight at the Receiving Home. Turnout not very good, only five, counting PHN and myself. However, we'll try again next year.

September 17 — A routine check on head-lice, passed out a few bottles of shampoo. We must have them under control this Fall. Last year we had so many complaints. So far we haven't had any yet.

September 22 — Believe it or not my favorite patient let me in today. He even spoke nicely to me. He's an elderly man. The PHN and I never give up although he hollers at us most of the visits. He needs all sorts of medications and bandages for his leg (ulcer) sore.

September 23 — Attempted suicide. Young woman, overdose of ASA's, pumped stomach out in time. Discharged next day.

September 27 — Visited Band Office this morning to talk to Band Manager about Birth Registration forms for newborns. He didn't know much about the matter, but said he will look into ordering from the Department of Indian Affairs in Campbell River. PHN and I repeatedly get calls from doctor's office receptionist complaining of no medical coverage on newborn babies and bills rejected. Still can't seem to get through to young mothers the importance of registering their babies as soon as they are born.

Re-visited young women on Birth Control today. Three were interested in getting something done, but didn't keep their word to come in last Wednesday to our Health Centre. However, I'll repeat visits again if they don't do so on their own to go see their family practitioner.

CNJ: Obviously, the job that you have chosen as a health educator is not an easy one. What is it about being a CHR that encourages you to keep on helping your people?

POWELL: I like my job, even though things get very hectic at times. People turn to me for help. It's hard for me to say no. I've learned to be patient with people ... Also, when I look around, I can see that things are getting better.

I learn as I go along in this job. New things happen day in and day out ... things I was never aware of before. I've learned to communicate better with my people now, I listen to their problems and I help them by looking and listening.

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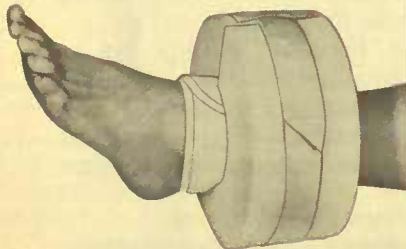

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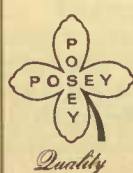
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Editor's note:

Space limitations in the September issue resulted in the following items being omitted from the Accession List for that month. These items appear below:

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Experienced Nurses (eligible for B.C. Registration) required for full-time positions in a new 300-bed Extended Care Hospital located just thirty minutes from downtown Vancouver. Salary and benefits according to RNABC contract. Applicants may telephone 525-0911 to arrange for an interview, or write giving full particulars to: Personnel Director, Queen's Park Hospital, 315 McBride Blvd., New Westminster, British Columbia, V3L 5E8.

Experienced Nurses (B.C. Registered) required for expansion to 463 bed acute, teaching, regional referral hospital located in Fraser Valley, 20 minutes by freeway from Vancouver, and within easy access of various recreational facilities. Excellent orientation and continuing education programmes. Salary: \$1184.00-\$1399.00 per month (1977 rates). There is an immediate need in coronary care, intensive care, operating rooms and hemodialysis because of increased services. Other clinical areas include medicine, surgery, obstetrics, pediatrics, emergency and rehabilitation. Apply to: Personnel, Royal Columbian Hospital, New Westminster, British Columbia, V3L 3W7.

Registered Nurse required immediately for isolated 12-bed hospital on central coast of B.C. Salary and benefits per RNABC contract. Low rent accommodation available. Apply to: Director of Nursing, Ocean Falls General Hospital, Box 640, Ocean Falls, British Columbia, V0T 1P0.

Nursing Supervisor required for 100-bed accredited Intermediate Care Unit of Penticton & District Retirement Complex, which also includes apartment tower for 156 Seniors and Recreation Centre/Day Care for all retired citizens of area. Responsibilities include total care programme for residents with emphasis on reactivation and motivation through activities. Salary according to RNABC agreement. R.N. with administrative and supervisory training and experience in long term care required. Apply, stating qualifications and references to Administrator, 439 Winnipeg Street, Penticton, British Columbia, V2A 6P5.

British Columbia

R.N. required for Intermediate Care Unit of Penticton & District Retirement Complex. Responsible to Nursing Supervisor for care programme for 100 residents and supervision of lay staff. Position could be shifts or permanent nights. Salary according to RNABC agreement. Apply to: Nursing Supervisor, 439 Winnipeg Street, Penticton, British Columbia, V2A 6P5.

Experienced R.N.'s or graduate nurses required for small hospital located West Coast Vancouver Island. Residence accommodation available. RNABC contract. Apply in writing to: Director of Nursing, Tahsis Hospital, Box 399, Tahsis, British Columbia, V0P 1X0.

Newfoundland

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Mr. R.L. Sheeler
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Applicants are invited for the position of Director of Nursing in a 47 bed, active treatment hospital.

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Reply in writing to:

The Administrator
Saugeen Memorial Hospital
P.O. Box 310
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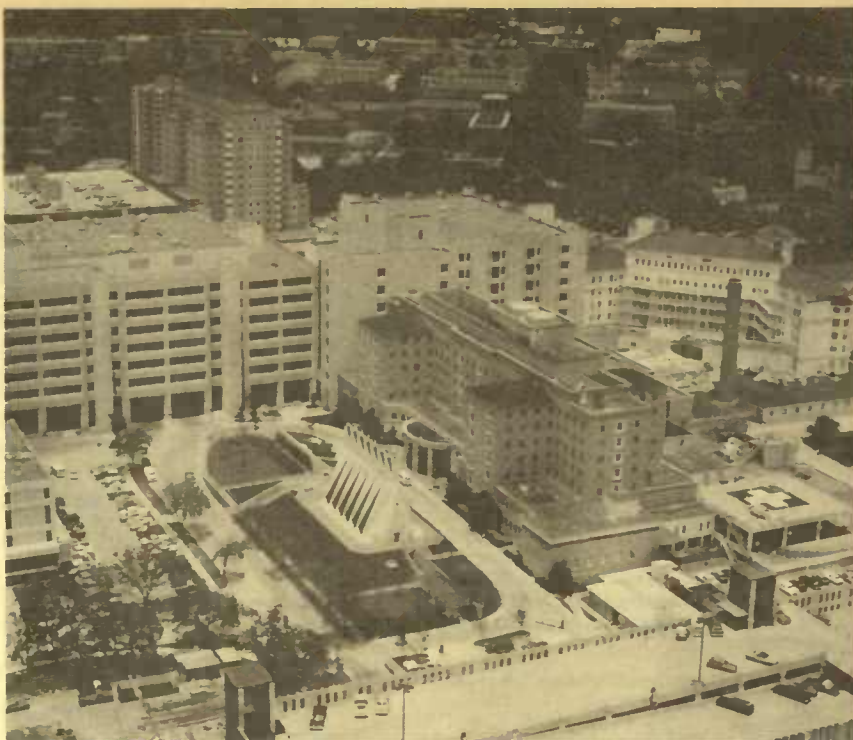
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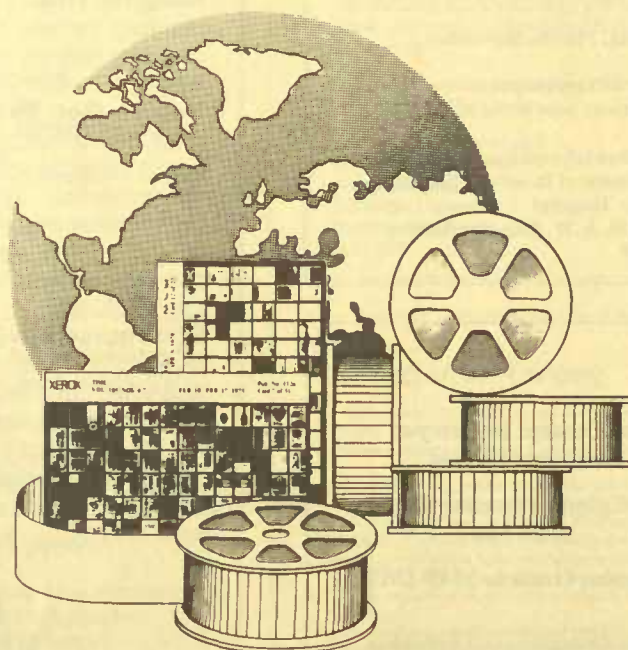
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Please submit resume to:

Mrs. J. MacPhail
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Vancouver, B.C. V5Z 1M9

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The above vacancy will exist in this unit which is currently being expanded. Under direction of the Head Nurse, the incumbent will be responsible for staff development in the unit. Duties will involve developing programs for orientation and continuing instruction of nursing personnel to provide knowledge, skills, attitudes and activities to maintain and improve present competencies within the Cardiac Monitoring Unit. The successful applicant will also be responsible for reviewing, developing, instructing and maintaining a patient and family education program.

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Please contact:

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Address correspondence to:

The Canadian Nurse

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Further information may be obtained by calling collect to Mr. A. Wozniak (204) 949-4183 in Winnipeg or Mr. G. Warrenchuk at (306) 569-5418 in Regina.

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Ottawa, Ontario K1A 0L3

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The Canadian Nurse

NOVEMBER 1978

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NOVEMBER 1978

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"Are we becoming less or more human in our approach to the terminally or critically ill patient?" This was the question Elisabeth Kübler-Ross raised nine years ago and nurses everywhere are still searching for the answer. Our cover illustration is by Deborah Gibson, one of the nine authors who offer us another look at death and dying from a nursing point of view in this month's CNJ.

The Canadian Nurse welcomes suggestions for articles or unsolicited manuscripts. Authors may submit finished articles or a summary of the proposed content. Manuscripts should be typed double-spaced. Send original and carbon. All articles must be submitted for the exclusive use of *The Canadian Nurse*. A biographical statement and return address should accompany all manuscripts.

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses Association.

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Perspective

Palliative care at the Royal Victoria Hospital

In 1973, studies of the quality of care being given to cancer patients who were dying in our hospital demonstrated many deficiencies in the way we were handling the care of the terminally ill and their families. We began to understand that the traditional goals of acute care hospitals — to investigate, to diagnose, to cure, to prolong life — are simply inappropriate to the individual whose need is to live as fully and as comfortably as possible until death comes. We also identified our need to develop a team with expertise and interest in palliative care, and a physical and psychological environment in which to deliver it.

Two years after it was begun in January 1975, the Palliative Care Service became an on-going part of the Royal Victoria Hospital. The PCS admits cancer patients for whom cure or prolongation of life are no longer reasonable objectives. The Service includes a consultation team, a twelve-bed in-patient unit, and home care and bereavement follow-up programs. Provision is also made for on-going research and education.

The patient and the family are the focus of care. The Service attempts to facilitate the provision of whatever care is required in the environment of choice to the patient and family, that is, in hospital or at home. Emphasis is on the alleviation and, wherever possible, prevention of the myriad symptoms which can torment terminal cancer patients and their families. An important dimension is of course pain control; the objective here is the achievement and

maintenance of a pain-free state without excessive sedation. And, with the majority of patients, it can be done. Serious attention is also given to the "lesser" symptoms: alleviation of thirst, prevention of constipation, meticulous mouth and skin care. In the delivery of this care, there is a commitment to open and honest communication and a belief that we must meet the person where he is at any given time.

No one discipline incorporates all of the skills which need to be mobilized on behalf of the patient and family facing the multifaceted experience of imminent death from terminal cancer. Nurses, physicians, physiotherapists, dietitians, social workers, volunteers, chaplains, legal advisers — all are necessary members of the multidisciplinary team of the PCS. All contribute to the development of care plans which will support and facilitate movement through the frightening experience of death and loss.

How does anyone cope with working continuously with this kind of clientele? There are significant stresses associated with the work and the question of who should be selected to be a part of the team is an important one.

All of the nursing personnel involved in the PCS are, without exception, persons who have applied for the position. We require a minimum of two years' previous experience and demonstrated ability in interpersonal relationships and in communications skills. A warm, sensitive, non-judgmental attitude is essential, as is personal maturity. A well developed sense of humor is a decided asset! Any individual who has experienced a recent personal



loss such as the death of a spouse, or a divorce, is encouraged to wait at least one year before considering working in palliative care. In our home care and consultation activities, we require five years of experience, and related post-basic education.

Experience has shown that the most level-headed, professionally competent, motivated and intelligent individual or group needs assistance in dealing with the significant stresses associated with palliative care nursing. Organized support systems must be built into the Service as a basic component. In the PCS, weekly group meetings are scheduled with the consulting psychiatrist. In these meetings people are encouraged and assisted to articulate their concerns, frustrations and problems. Two two-day retreats for all the staff have permitted full participation of all team members in critical review, problem identification and problem solving.

There are of course other, less formal ways of supporting the group, and of their supporting each other. Sharing fun becomes very important when a group is constantly sharing pain.

I am proud that the Department of Nursing in this hospital has been actively involved in the development of the Palliative Care Service. I am even prouder of the

contribution the nurses who work on the PCS have made to the growing knowledge about palliative care and to the education of people from many disciplines who desire to learn from their experience. Best of all, at least some of the patients and families in need of this specialized care are now receiving it.

—Sheila O'Neill, nursing director, Medical Pavilion, Royal Victoria Hospital, and first vice-president, Canadian Nurses Association.

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Input

The Canadian Nurse invites your letters. All correspondence is subject to editing and must be signed, although the author's name may be withheld on request.

How high is high?

Canadian physicians were pleased to learn via Jannice Dick's article (July/August, 1978) that nurses recognize and share our concern about the economics of health care. Unfortunately Miss Dick has fallen into the trap set by some of our more pessimistic critics and has misinterpreted some of the figures and events that have succeeded in convincing many that health care costs are getting out of hand.

Twenty-four years ago, according to the Royal Commission on Health Services Report, Volume 1, page 428, Table 11-2, the percentage of the GNP spent on health care was 3.38 per cent, not 1 per cent. The CMA has repeatedly demonstrated that during the period from 1971 to 1976 health care costs have been held to between 7.2 per cent and 6.9 per cent of the GNP. Health care costs have actually shown a slight downward rather than upward trend. It is therefore very unlikely that they will reach 10 per cent of the GNP by 1980.

To say that increases in demand for and supply of health services are responsible for increasing total costs is self-evident. However, to imply that the third party payment system is one of the most important factors contributing to cost inflation deserves some scrutiny. The most significant factors contributing to increasing costs per service have been a) inflation, b) tremendous strides in technology improvement which have opened new avenues in treatment and c) significant increases in hospitalization costs, themselves the result of increased technology costs and well-deserved adjustments of hospital

personnel salaries (the latter account for 70 per cent of hospitals' operating costs).

Certainly, the cost of cosmetic surgery could not have contributed to an increase in costs (in terms of government expenditures) because it is not an insured service: cosmetic surgery is not paid for out of the public purse.

Furthermore, although historically Canada may have suffered a shortage in supply of physicians and educational resources, this is no longer true.

The sum of these facts makes it impossible to agree with the unqualified statement that "With the introduction of third party payment, utilization of health care services increased so much that it became evident that the price was simply too high". Is the author talking about the price or the cost of health services? We agree that the cost is high but is it too high? As for the price, the same arguments used for justifying the price of nursing services could be used to justify the price of medical services and we are convinced that the current price of medical services is not too high. What needs to be established is whether Canadians are willing to pay the price for the kind of services they need and want. We tend to think they are, and that our health care system analysts have not adequately felt the pulse of the man on the street.

—K.O. Wylie, M.D.,
President, The Canadian
Medical Association.

Tuned in mother

Regarding breast-feeding and its effects on the mother who has had "a complicated pregnancy, long hard labor, or hemorrhaged" (Input,

September 1978), the "pros" of breast-feeding for the baby are well documented but perhaps the "pros" for the mother haven't been emphasized enough.

My baby is eight months old and still wakes at least once during the night; the usual procedure for me (and for many other nursing mothers) is to take the baby to bed, where both of us usually fall asleep. Surely this is much easier than getting up to heat a bottle while the baby screams with hunger!

A large part of successful breast-feeding is a positive attitude and knowledge on the subject (the better to resist the "advice" of well-meaning friends, relatives and physicians).

As for the "spotless home" — who are you trying to impress?? No one expects a person who has had major surgery to be running around cleaning house, so why should it be expected of a woman who has just had a baby?? Not having a spotless house shouldn't be a deterrent to any real friends — a baby stays little for only a short time, but the house won't fall down if it's not "spotless".

Breast-feeding is a lovely experience and really "tunes you in" to the baby and his needs, plus being helpful in returning you to normal after delivery.

—Mary Hyslop, Chester,
Nova Scotia.

Mother of three

...I counted my blessings that this form of nourishment was possible, as it meant no formula to mix, no dirty bottles to wash and sterilize, no added expense for feeding, and no getting out of bed in the middle of the night to heat a bottle—the babe was in bed with me where we both were warm and content.

I found that I was able to return to a full-time job when finances made this necessary, after the third child was six weeks old. I left a bottle with the sitter for the one feed I had to miss and we all got along fine. I did not have outside help, but my husband was a great help in caring for the children and helping with the laundry and housework. We did not have a "spotless" house, but it was not a pigpen either.

I became adept at buttering toast with one hand while carrying a babe at my breast with the other and found that the rocking chair could accommodate two toddlers, myself and a suckling child, making it a "Family Affair".

I maintained my weight and napped during the day when the children slept. I felt fulfilled. My hemoglobin did not drop and I did not require supplemental iron.

My sympathy to those mothers who feel society is pressuring them as Ms. Shultz suggests. I feel this is a state of mind however. For myself, I was only doing what came naturally, and there was no La Leche League in my day.
—Marilyn Brotherton, Reg.
N., Brandon, Man.

A chance to help

We would like to thank the Canadian Nurse for granting copyright clearance for the Radio Reading Service to broadcast articles of interest to the print handicapped.

This service is the first of its kind in Canada and broadcasts a great variety of reading material to listeners who are blind, or unable to read for medical reasons. The radio signal serves an area within a 50 mile radius of Burlington, Ont., and listeners use a special receiver

obtainable at no charge from the South Central Regional Library System.

We are co-producers of a weekly half hour show on health, and articles from the Canadian Nurse as well as from other current, popular publications are read to provide the print handicapped with up to date information on the health scene.

Anyone who would like to volunteer their services either as a reader, or as a studio operator, or would like to pass on more information concerning the service to their clients is asked to contact the Radio Reading Service, Oakville Public Library, 1274 Rebecca St., Oakville, Ont., or telephone 416-827-4455.
—Carolyn Keyworth, B.Sc.N., Susan Rahan, B.A., Milton, Ont.

Medical treatment of minors

In her article "Minors in the Health Care System" (September) Corinne Sklar writes that in "only three of the provinces has there been provision under legislation reducing the age of consent for medical treatment..." and does not include New Brunswick. I would like to refer her to the "New Brunswick Medical Consent of Minors Act" (S.N.B.M.-6.1) assented to June 24, 1976, which states: "The law respecting consent to medical treatment of persons who have attained the age of majority applies, in all respects, to minors who have attained the age of sixteen years in the same manner as if they have attained the age of majority."

The act goes on to elaborate on what is to be done if the minor is "incapable of understanding the nature and consequences of the medical treatment",

and the conditions under which application may be made to the Supreme Court of New Brunswick for "an order dispensing with consent." The age of majority in New Brunswick is 19.

—Irene Leckie, Dean, Faculty of Nursing, University of New Brunswick, Fredericton, N.B.

Giving care together

We are responding to the recent publicity around the nurse practitioner, the viability of this health professional and the uncertainty of a continued educational program for nurse practitioners.

It is unfortunate that, at a time when health care costs are being scrutinized, individual physicians

employing nurse practitioners have not been given financial reimbursement or assistance from the ministry of health, to encourage the employment of nurse practitioners. At present, OHIP reimburses physicians for their services but not for services rendered by the nurse practitioner.

As a result, it creates a financial burden for a physician to hire a nurse practitioner. The exception, of course, is the case of the physician or the patient care setting, financed by a global budget, where all the costs of the operation are paid by the ministry of health, in a global salary. The Burlington Study is a good example where global budget allowed physicians and nurse

practitioners to give good care together.

We suggest, as others have, that OHIP allow physicians to charge for a "nursing service", e.g., birth control counseling.

It is time the ministry of health supported the role of the nurse practitioner in a concrete way by assisting physicians and those in other patient care settings to employ this health professional. The consumer would benefit by increased quality of health care, at a minimal cost.

—Tish Butson, R.N., B.Sc.N., Johanna Mousseau, R.N., B.Sc., Nurse Practitioners Family Practice Unit, McMaster University Medical Centre, Hamilton, Ont.

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Have you ever thought of combining two careers in one? As a Canadian Forces nurse you could, because you would also be an officer, eligible for regular promotion, enjoying a minimum of four weeks vacation your very first year, free transportation privileges to many parts of the world, early retirement including a generous lifetime pension and a number of other benefits. The Canadian Forces will give you every opportunity to continue your nurse's training, while using the skills you already have in one of the many military medical installations in Canada or overseas. You might qualify for flight nurse's training or even for a complete doctorate study course.

If you're a graduate (female or male) of a school of nursing accredited by a provincial nursing association and a registered member of a provincial registered nurses' association, a Canadian citizen under 35 with two years' post-graduate experience in nursing, you owe it to yourself to enjoy two careers in one. Contact your nearest Canadian Forces Recruiting Centre or write to: Director of Recruiting and Selection National Defence Headquarters Ottawa, Ontario K1A 0K2



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Input

Death and dying

...I wonder how many nurses are aware of "Life after life" and "Reflections on life after life", two books written by Raymond A. Moody Jr. M.D., both published by Bantam Books. Dr. Elisabeth Kubler-Ross has written the preface to "Life after life".

I would recommend these books to all those concerned with the issues of death and dying.

—Dorothy Fulford,
Employment Relations
Officer, Ontario Nurses
Association, Ottawa Office.

Former dean remembered

Catherine Aikin's death has saddened her many friends and has deprived the nursing profession of one of its gentlest leaders.

It was my privilege to have been one of Catherine's colleagues at the University of Western Ontario. During her tenure as Dean of the Faculty of Nursing she encouraged and supported faculty and students through a decade of change within the faculty and was the pivotal person who showed great tolerance for differing opinions and a consistent willingness to listen. Her marvellous sense of the ridiculous will be remembered and greatly missed.

The R. Catherine Aikin Nursing Scholarship Fund presently being launched at the University of Western Ontario offers a way to remember her in the manner she would like best.

Donations may be made to the name of the fund in care of The Faculty of Nursing, University of Western Ontario, London, Canada, N6A 5C1.

—Eileen Healey Mountain,
R.N., B.Sc.N., M.A.,
Ottawa, Ontario.

Oneupmanship

I read with interest the article "Games Nurses Play" (July/August 1978). Surely the examples cited are rather extreme, and surely the "games" are played by individuals, not by the nursing or medical profession.

Some people have the ability to get along with and communicate with others; some do not.

Real life example number one:

Doctor A: Give the patient 10 mg of Valium (tone implies: "right away").

Nurse A: TEN MILLIGRAMS??!! (tone implies: "are you nuts?")
Volume causes old man to drop glass containing his teeth.)

Doctor A: Yes. 10 mg. (tone implies ability to walk on water and divine right.)

Real life example number two:

Doctor B: Please give the patient 10 mg of Valium.

Nurse B: 10 mg. Isn't that a bit much?

Doctor B: Hmm, maybe. Would 5 be better?

Nurse B: I think so. He's a bit frail.

Doctor B: OK. 5 mg.

It's not doctors or nurses — it's individuals.

They're not games — they're people's personalities.

—Ron Tennenhouse, M.D.,
Toronto, Ontario.

More about Crohn's disease...

Your article "Crohn's disease: mourning the losses" greatly interested me.

This I would think is an extreme case of Crohn's disease. Yes, it's a good idea to inform readers of what the disease entails, but, why not add "Not all cases of Crohn's disease are this severe." For example, I'm an R.N. working full time in ICU and I have Crohn's disease.

Another point I would like to make is that steroids

appear to be the cornerstone in the treatment of Crohn's disease along with a maintenance dose of Salazopyrine.

—Name withheld at author's request.

Pediatric nurses speak up

In reply to the recent letter "Protecting little ones" in your September issue, I would like to come to the defence of pediatric nurses.

Yes, children do have rights. However, one of these is the right to proper care and sometimes the mere presence of a parent is detrimental to the well-being of the child.

For instance, a two-year old in severe respiratory distress due to croup. Mother is at the bedside very anxious. Her anxiety is relayed to child who becomes frightened, agitated, screaming, doesn't want to stay in his croupette, wants to be held by his mother even though he needs the oxygen and humidity in the croupette.

Or, another example, staff had a very difficult time starting the I.V. Respirations increasing. I.V. interstitial because of kicking child. Child must now go through the trauma of having his I.V. restarted. Respirations now very labored. Child will not settle. Situation evaluated with careful consideration of parent and child. Child is better off with mom leaving. Shortly after mom leaves child settles down and goes to sleep.

As a mother and a pediatric nurse I do not feel in these circumstances we are depriving our little ones of their rights.

—Bonnie Renwick,
Edmonton, Alberta.

Can you help?

Here in Papua New Guinea, we have a medical school library of only 10,000

volumes. Because, in the absence of any other, we also act as national medical library, we serve not only staff and students of this faculty, but also the needs of all medical, dental, paramedical and research personnel over a remote and inaccessible area larger than the State of California.

Many of these work in isolated hospitals whose only contact with the capital is the airstrip and the radio or telephone.

The challenge of providing a medical library and information service to the nation is one we are happy to accept, but our resources are too slender to be effective. We shall soon also be serving a new dental school, but with no special funds for extra book provision.

Our immediate need is to improve the library's bookstock, increase our range of journals and provide more extensive sets of back runs. On behalf of the present and future medical profession of Papua New Guinea, we are seeking your assistance.

Please send whatever you can: money, books, gift subscriptions, back runs of medical, dental or nursing journals, or health education material of any kind (including audio-visual material). All will be useful.

Our address is Medical Faculty Library, P.O. Box 5623, Boroko, Papua New Guinea.

—A.C. Butler, Librarian,
University of Papua, New Guinea.

Editor's Note: The University of Papua is among those receiving duplicates from the library of the Canadian Nurses Association under the auspices of the Overseas Book Centre.

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News

Photo by Studio Impact



As the countdown for Immunization Action Month began on November 1st, nurses across the country prepared themselves for a busier than usual schedule in schools, clinics and offices. Above, Viola Galan, of the Ottawa-Carleton Regional Health Unit, makes sure that her client is protected from diphtheria, tetanus and polio. Preschool children have been chosen as primary targets by the nine agencies sponsoring the national public awareness campaign which runs from November 1st to 30th.

Emergency personnel hold first interdisciplinary meeting

Mid-September marked the first time in Canadian history that emergency personnel from a variety of professional backgrounds — physicians, nurses and ambulance attendants — met as colleagues for a three-day interdisciplinary seminar.

The occasion was the first annual Ontario Assembly of Emergency Care which took place at the Skyline Hotel in Toronto from September 11 to 13.

More than 700 emergency personnel, mostly from Ontario but with some representation from other provinces and from the United States, attended the meeting. They heard one of their members, emergency physician Dr. L. Kelly of Kitchener, Ontario, tell them that "the concept of emergency care is coming of age in Ontario. The (emergency) team is together

and now we can start working."

Until this year, the three sponsors of the meeting, Ontario's Emergency Physicians, the Emergency Nurses Association of Ontario (ENAO), and the Association of Casualty Care Personnel, have held separate annual meetings with occasional joint one-day workshops.

Discussion during the meeting centered on the educational needs of emergency care personnel. Lectures on a broad range of topics including febrile convulsions, burns, sprains and strains, handling abusive patients, cardiac drugs and antidotes to poisoning were well attended and generated much discussion. Participation workshops were held concurrently with the lectures and dealt with practical aspects of emergency care such as chest

auscultation, defibrillation, splinting and bandaging.

In addition, participants were able to view films on emergency care and take part in Basic Life Support CPR workshops presented by the Ambulance Services Division of the Ministry of Health. Nurses and other delegates also had an opportunity to attend a simulated airport disaster at the Toronto International Airport and see the latest in transport procedures and equipment.

Representatives from the three sponsoring groups presented a panel discussion dealing with mandatory continuing education in emergency care. Speaking on behalf of the College of Nurses of Ontario, Helen M. Evans urged nurses working in an emergency setting to set standards of practice in their own specialty.

Interviewed on the subject of education for emergency nurses, Elizabeth Rideout, educational resource person for ENAO and a clinical specialist at St. Joseph's Hospital in Hamilton, stated that at the present time there are not enough educational programs in existence in Canada for nurses in emergency other than one- or two-day workshops. The ENAO, however, is now in the process of developing an educational program to meet the needs of these nurses and the association hopes to have a pilot project in operation by September, 1979.

The only organized group of emergency nurses in Canada, the ENAO has come a long way since the organization began in 1970 under the leadership of Carole (Lautenslager) MacDonald. There are now close to 800 active members in 11 provincial districts.

The aim of the

association is to provide improved emergency services to the public by establishing a recognized educational program geared to emergency nurses, by increasing public and professional awareness of the development of emergency nursing as a specialty, and by encouraging the development of on-going educational programs within hospitals.

The ENAO is affiliated with the Registered Nurses Association of Ontario as well as other professional groups in the province. Recently, the ENAO has collaborated with RNAO and the Ontario College of Nurses in the preparation of a position statement concerning the roles of the paramedic and emergency nurse, both in the hospital and outside that institution. The report is scheduled to be released in the near future.

At a business meeting held during the assembly, ENAO members elected a new slate of officers for the coming year. They are:
President: Sandy Easton, Hamilton;
Past-president: Kathy Kitney, Hamilton;
Vice-president: Joyce Davis, Kingston;
Secretary: Margaret Pook, Toronto;
Treasurer: Mary Angi, Toronto;
Editor: Janet Parsons, Hamilton;
Chairman of education committee: Elizabeth Rideout, Hamilton.

Anyone interested in the ENAO or having suggestions to make concerning the new educational program is invited to contact: Sandy Easton, Patient Care Coordinator, Emergency Department, McMaster University Medical Centre, 1200 Main St. W., Hamilton, Ontario.

BC publishes skills manual

"Essential Manual Skills for a New Graduate", an itemized description and rating of 150 things new nurses need to be able to do with their hands, is on its way to hospitals, schools, government officials, doctors and nurses in the province of British Columbia.

The document, which was adopted by directors of the Registered Nurses Association of British Columbia last June, sets out skill specifications for nurses in nine clinical areas: medicine, surgery, obstetrics, pediatrics, psychiatry, extended care, rehabilitation, operating room or recovery room, and intensive care or emergency.

The guidelines are meant to assist hospitals employing new graduates and the graduates themselves, basic nursing programs and their students and experienced registered nurses.

"While manual skills are only a portion of nursing practice, they represent one area where the new graduate experiences difficulty," according to an introduction to the document. "The information (should) bring a greater degree of specificity to common expectations of the new graduate than has previously been possible."

The final skill lists are the results of an eight-month project involving some 231 registered nurses working in 16 hospitals across the province. Their efforts were coordinated by a steering committee whose members included: chairman Ruth Anderson, Sorrento; Diane Brennan, North Vancouver; Ruthella Cooper, Victoria; and Nancy Hutton, Vancouver.

NBARN awards scholarships

Fifteen New Brunswick students will share a total of more than \$5,000 in scholarship funds awarded by the NBARN for the 1978-79 scholastic year.

Two nurses, Fernande Losier of Bathurst and Judith Mann of Campbellton, each received \$1,000 scholarships for studies at the Master's level. Losier is attending l'Université de Montréal and Mann the University of Toronto.

Other winners are: Jean Milner of Blackville and Joyce McDowell of Saint John, who each received Muriel Archibald scholarships valued at \$500; Heather Erb, Saint John; Arlene Gregor, St. Stephan; Line Lavoie, Grand Falls; Nancy Plume, Stanley; Marie-Mae Rossignol, Edmundston; Francine Thibault and Jacqueline Grondin, Ste. Anne de Madawaska; Sylvie Parisé, Caraquet; Elaine Bell, Woodstock; Ruth Kirk, St. Andrews; Mary Sherwood, Norton; Imelda O'Connor, Hampton.

Health happenings

A private research institute in California recently announced the successful laboratory production of human insulin using recombinant DNA technology. The synthesis of human insulin was done using a process similar to the fermentation process used to make antibiotics. Until now insulin was extracted from the pancreas of animals (8,000 pounds of animal pancreas glands was needed to make one pound of insulin). The new process will produce ample quantities to meet the growing demand and more importantly will produce a chemically identical human insulin.

CNA to honor outstanding nurses

The Board of Directors of the Canadian Nurses Association has released revised criteria for selection of members of the profession to be honored by the national association for their outstanding contribution to nursing.

This year, for the first time, the association is inviting nominations from groups or individuals other than CNA association members. Hospitals, universities, individuals and others with a special interest in advancement of the profession are being invited to nominate candidates for the awards which will be presented at the next annual meeting of the association in Ottawa on March 29, 1979.

To be considered for the award, nurses must meet two or more of the following criteria:

1. Nurses who have made a significant and innovative contribution to the health care of Canadians, by:

- creating or assisting in the organization and implementation of new health care/education programs;
- demonstrating clinical expertise which results in a marked improvement in the health care delivery system.

2. Nurses whose activities at the national and/or international level have resulted in increased status and public recognition for the nursing profession as a whole. These activities would include:

- outstanding contribution to an organization such as WHO, ICN or CNA;
- administrative ability at a senior level of the public or private sector in education and/or service;
- leadership and service within the national

professional association.

3. Nurses whose personal contribution has had a positive impact on the nursing profession in Canada and/or other countries. Leadership may be in the areas of:

- published material;
- expertise in a clinical area;
- research or teaching activities;
- creative work or performance;
- employment relations;
- community health.

The association reminds those who are considering nominating nurses that all criteria apply to achievement on a national scale and points out that "Although many nurses make an outstanding contribution to their profession by demonstrating competence and leadership in clinical, administrative or educational fields at the provincial/territorial level, the purpose of this award is to honor those nurses whose achievements have had significant, positive impact on nursing at the national level."

Association members should not restrict their consideration of possible candidates to residents of their province/territory.

Complete documentation, as specified in the criteria for selection of nurses to be honored, must accompany each nomination.

All submissions must be in writing and must be received at CNA House by January 15, 1979. Please address your letter to: *Awards Committee, CNA House, 50 The Driveway, Ottawa, Ontario K2P 1E2.* ►

News

More than meets the eye

The Labor Relations Department of the Canadian Nurses Association warns that unions which rely on the Consumer Price Index as an important tool in their negotiations could be the losers if, as predicted, the CPI breaks its seven-year upward trend and takes a drop later this year.

Such a decline, according to CNA Labor Relations spokesman Glenna Rowsell, would "only be the result of a change in the way Statistics Canada calculates the Index."

The revised CPI, if it underestimates the real level of inflation, could have severe implications on the millions of wage and COLA dollars that are tied up in every

percentage movement in the CPI. For every one per cent drop in the Index, the federal government on the other hand, saves \$225 million in pensions, family allowances and other programs geared to the Index.

"Lower income workers will be hit even harder by a CPI that could underestimate real inflation," Rowsell points out. "Lower income groups (pensioners, part-time and casual workers, minimum wage earners, etc) spend a greater portion of their earnings on food, clothing, and shelter than do higher income groups. It is these items in the Index that tend to increase in price more rapidly than most other goods and services."

NBARN studies PR proposal

A three-year public relations program, aimed at doubling membership participation in the New Brunswick Association of Registered Nurses, is under study by the association's elected officials.

Analysis of membership participation in association activities in the past indicates that less than one per cent of the membership was professionally involved at any given time.

To curb this involvement slump, the PR proposal suggests creation of a more vibrant and effective communications system, creation of more membership

services, and development of a higher profile vis à vis NBARN members.

Did you know...

The International Association for Enterostomal Therapy wishes to announce the formation of scholarships to be awarded to registered nurses interested in working in this specialty field and in improving nursing care to the ostomy client. Application deadline is December 1, 1978. Contact: *International Association for Enterostomal Therapy Inc., Central Office, 1701 Lake Avenue, Glenview, Illinois, 60025.*

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Here's How

Rubbing Out Pressure Sores

The geriatric nurse is constantly fighting the causes of bedsores. When a pressure sore does develop, however, the primary tissue need, especially for an older person with poor peripheral circulation, is for an improved blood supply.

At Bonnie Brae Nursing Home in Fergus, Ontario, we have tried a new form of treatment for broken pressure sores with considerable success. We use a simple electric massager — it can be purchased for less than 15 dollars at a department store. It is plastic, small and lightweight, and plugs into an ordinary outlet. The dial is simple, and attachments are easy to use and clean.

We discovered that the hand massager, applied directly to the involved skin area, heals superficial sores in a few shifts. We have had no experience with deep pressure sores, as superficial areas heal so quickly.

The doctors we have approached concerning the use of the massager on the patient's skin, have not hesitated to encourage its use. We used almost continuous treatment with the massager with one dying patient whose skin was constantly breaking down. We positioned the massager with supporting pillows against one hip and then turned the patient to treat his other hip. The treatment was always closely supervised, but propping the massager left us free to do other care. For other patients, 20-minute treatments with the massager, twice a shift, was usually sufficient to heal superficial pressure sores.

We hope that this information may be helpful to others in their continuing fight with an old problem.

— Sally Cameron and Thelma May, Bonnie Brae Nursing Home, Fergus, Ontario.

Diaper Controversy

New mothers often feel torn between the cloth diapers their mothers used and the newer disposable diapers with an outer plastic layer. When mothers ask me which type is better for their baby, I tell them that from my experience, I have noticed only one difference.

In changing diapers before a q3h feed, I have noted that a soaked cloth diaper feels cold, but that the outer plastic layer of a disposable diaper seems to retain heat, so that the soaked disposable diaper is warm. This is of particular importance in the care of the low-birthweight or premature infant who has a lesser ability to maintain body temperature.

— Darlene Laybourn, relief nurse, intensive care nursery, St. Paul's Hospital and Vancouver General Hospital, Vancouver, B.C.

Breast Binder

While working on an obs./gyn. floor, I discovered that some nurses went to a great deal of trouble to locate a "ready made" breast binder for a patient. I was taught that you could make your own breast binder using a hospital towel. Fold the towel down about two inches, lay it across the bed, and have the patient lie back on it. The top of the towel should be just under her arms. Instruct the patient to hold her breasts up and in, then apply the towel tightly and pin, folding in the ends. This method is also a helpful teaching idea to give your postpartum patients who will not have a breast binder at home, but may need one.

I have found this idea saves me time and steps searching for supplies that may not be available.

— Charlene Martineau, St. Bruno, Quebec.

Every nurse has practical ideas gathered from his or her experience on how to make life a little easier for nurses and for patients. *Here's How* is a column for you and your ideas. If you have an original and practical suggestion that you think might help other nurses to improve any aspect of patient care, why not share it with other nurses? We'll send you \$10. for any suggestion published. Let's hear from you. Write: *The Canadian Nurse*, 50 The Driveway, Ottawa, Ontario, K2P 1E2.



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YOU AND THE LAW

Teenagers, birth control and the nurse



Corinne Sklar

One result of the "sexual revolution" of the sixties and early seventies has been an imputed relaxation of sexual taboos in adult society. These changes have both received impetus from and been reflected in teenage sexuality. Generally, however, it is safe to say that adult (and parental) attitudes have not been liberalized to the same degree as those of the next generation. Often, parents' liberal public pronouncements are completely opposite to their personal position regarding the conduct of their own teenage child.

The law tends to reflect this dual position. On the one hand, the capacity of minors to consent to medical treatment is limited and vague. On the other hand, federal, provincial, and municipal governments institute and publicize programs designed to facilitate and encourage dissemination of contraceptive information to all Canadians, including minors. It is the persons responsible for delivering these health care services who are left to face the dilemma created by silence and conflict on the part of the legislators.

In September, this column examined the minor's legal capacity to give consent for medical and nursing treatment. The elements of teenage sexuality and contraception further distort the already uncertain position of the minor. Is there legal liability when nurses counsel young persons regarding birth control? Must parents be informed that such counselling is being undertaken? Must parents' prior consent be sought?

The dilemma is more sharply focused for physicians, who require valid consent before commencing treatments and examinations. It is the physician who prescribes oral contraceptives, fits diaphragms, inserts I.U.D.'s. It is the physician who bears the responsibility for ensuring that the consent obtained is informed. Thus, there must be an explanation of the nature and consequences of the proposed treatment and the risks attendant thereupon. The legal position of the physician is not, however, the focus of this column. Nor is it the intention of the author to deal with the pro's and con's of the abortion issue.

The need for counselling

Any consideration of the problem of unmarried minors and contraception raises a host of complex and controversial issues. Conflicting and competing social, religious, and moral values and attitudes influence personal and professional conduct when one is confronted with this problem. The following statement

taken from the Badgley Report on Canada's abortion laws says it well:

*"Sexual behavior has two masks in Canadian society. Alternately it is private or public, sacred or profane, and wholesome or obscene. Reflecting a gradual change in values, some aspects of sexual behavior which a short time ago were censored or considered to be criminal are now more widely accepted. There has been much fantasy and ignorance and little fact about the changes in sexual behavior and contraceptive use which have taken place and what they mean to our way of life. Dual standards are widespread. What an individual might do and accept personally, he might not say in public or accept in individuals who held high public office."*¹

The underlying societal anxiety seems to derive from the belief that the widespread availability of contraceptive devices to teenagers will encourage and increase their sexual acting out and immorality. The idea persists that public policy against such promiscuous conduct is a reason justifying state control and intervention. The history of the crusade for free public access to birth control methods and information reflects this view. Margaret Sanger began her drive for birth control measures in the 1920's but it was not until 1969 that the criminal sanctions against the dissemination of contraceptive materials and information were removed from our Criminal Code.

In a recent United States Supreme Court decision,² the Court noted that there was no conclusive evidence that the availability of birth control is the differential that determines a teenager's sexual conduct. The Court took judicial notice that "with or without access to contraceptives, the incidence of sexual activity among minors is high, and the consequences of such activity are frequently devastating."³ Denial of access to contraception to "punish" youthful sexual acting out is to deny the realities of today's social life and fabric. The consequences of such denial, notably pregnancy, are harsh, and exact an unnecessary price from our teenagers physically, psychologically, socially — as well as from the child born of this denial.

Today's teenagers DO need access to contraceptive information, a fact that is apparent from available statistics. Eight years ago in Canada, there were 14,801 illegitimate births among mothers between the ages of 15 and 19 (when rates are highest)⁴. Since then, changes in Canadian abortion laws have resulted in a decrease in the number of illegitimate births but the need for contraception remains as indicated by the fact that in 1974 a total of 12,481 therapeutic abortions were performed on

adolescents in this age group⁵. Although the physical hazards of pregnancy are borne solely by the adolescent woman, the problems raised by limitation or denial of birth control information and methods should not be focussed only on women. Teenage boys also need counselling in the area of sexual conduct regarding the prevention of pregnancy and venereal disease. Hence this column deals with minor teenagers generally although admittedly, the difficulties and hazards are greatest for Canadian young women.

Studies continue to show that despite school-sponsored classes in sexual development, teenagers still harbor grave misconceptions regarding pregnancy and birth control. Young girls still tend to rely on boyfriends to prevent pregnancy. As well, they continue to believe in the effectiveness of ineffective methods, e.g. coitus interruptus.⁶

Effective teaching and counselling as preventive measures are clearly crucial and here the nurse has a key role for often she is the one who gives the counselling. Thus, sensitive listening and open communication are important elements in dealing with teenagers.

Nurses also hold a range of views on teenage sexuality and contraception. It is important to be aware of one's personal attitudes and biases regarding human sexual conduct. The personal views of professionals should not be imposed on patients nor should one's personal negative value judgments of the patient's conduct influence the quality of care given to the patient. Nurses need to remain cognizant of the physical and emotional needs of teenagers as they pass through the turbulent adolescent years. A sensitive, open, non-judgmental approach is needed.

Legal liability

The minor's capacity to give consent to treatment is of major relevance, for without consent a physician or nurse may incur liability. Thus if it were found that no valid consent had been obtained, the nurse assisting a physician in examination or treatment of a patient might be liable for the civil wrong of battery. While some provinces permit teenagers under the age of majority to give a valid consent to treatment (B.C. - sixteen years; Ontario - sixteen years in hospital only; Quebec - fourteen years⁷), most provinces restrict capacity to give such consent to those who have attained the age of majority. The exceptions to such restriction include emergency situations and emancipated minors (those minors either completely economically self-supporting away from home or those socially liberated while still under parental financial support). A third exception concerns mature minors (so-called in the United States). This refers to minors who have sufficient maturity and intelligence to understand the nature and consequences of the proposed treatment and can come to reasoned decisions whether to accept or reject it. This was the test applied by Mr. Justice Addy in *Johnston v. Wellesley Hospital*⁸ in his consideration of a minor youth's capacity to give a valid consent to medical treatment. It is likely that meeting this test would confer valid capacity to give consent on a minor teenager.

The problem arises because teenagers, sensitive to their own privacy and fearful of parental wrath on learning of their sexual conduct, frequently refuse to permit physicians and nurses to inform or consult with their parents. This refusal prevents the professional from obtaining concurring parental consent. Faced with such a position, the professional may refuse to treat the minor and thus deny him health care which may not be necessary in the "emergency sense" i.e. immediate threat to life and limb, but which nevertheless IS necessary to the health and well-being of the patient. The patient may be referred elsewhere (and the teenager may decide to "forget it because who needs the hassle?"). Or, the professional may decide to proceed with treatment in the best interests of the minor patient. While the latter position may leave the professional open to a battery suit or professional disciplinary proceedings, if the professional can show the necessity of the service rendered, the minor's refusal to involve parents and the

"maturity" of the minor, then likely no untoward consequences will follow.

Physicians and nurses often do deal directly with minors without the consent of their parents. Yet the number of reported legal cases in Canada remains miniscule. This may be because, although parents may initially be irate, they eventually recognize the need for contraception in their sexually active teenagers. Also, parents are likely unwilling to bring the issue of their child's sexual conduct under public scrutiny in a courtroom. There is also the aspect of parental responsibility to safeguard the health of their child. To deny health care and counselling to a sexually active teenager does not promote the child's best interests ultimately. However, it is important to realize that an absence of litigated cases does not preclude the possibility of a lawsuit occurring. It is best to try to obtain the patient's approval to include parents. If this is not forthcoming, then a reasonable professional assessment of the need and the patient's maturity and understanding are necessary and should be recorded. The value of complete and accurate records made at the time can never be overestimated.

The only reported Canadian case involving a physician and contraception for a fifteen-year-old minor is the 1970 British Columbia case, *Re Medical Act: Re Dr. "D"*.⁹ In that case, the physician appealed his censure by a medical inquiry committee. The Court refused to interfere with the findings of the committee. Charges included insertion of an I.U.D. in a 15-year-old patient without parental consent and infamous or unprofessional conduct in kissing the patient and fondling her private parts. Although lack of parental consent was discussed, there was no question of battery raised in the proceeding. It would seem that the primary reason for the physician's censure was the sexual impropriety with his youthful patient. The Court's finding does not seem to say that a 15-year-old can never give valid consent for contraceptive treatment without parental consent. Indeed, counsel for the College stated that in some circumstances a minor can give valid consent.

There is another source of potential liability, which has as yet not come before our courts. Again, this does not preclude the possibility of such an action. The source of potential liability is the *Juvenile Delinquents Act*¹⁰. This Federal Act states that included in the term "juvenile delinquent" is any child who "is guilty of sexual immorality or any similar form of vice". The Act goes on in s33(1) to impose liability on any person who knowingly or wilfully aids, causes or abets the child's delinquency or who does any act producing, promoting or contributing to a child's being or becoming a juvenile delinquent. "Sexual immorality" is not defined in the Act nor is there much guidance from reported cases.

Hopefully, however, a court today would define "sexual immorality" in the light of today's attitudes and would interpret s33(1) as being directed towards its procuring or promotion of delinquency. On that basis, prescription or counselling of contraception by a physician or nurse would likely not be included in the commission of the offence for the intent of the health worker is not to aid, abet or promote sexual misconduct. It is to promote the interests of the minor's health and well-being. Liability under this statute would be unlikely.

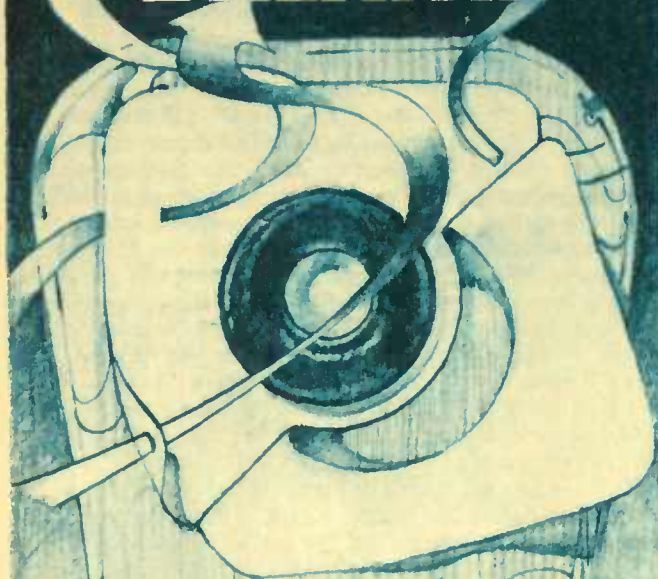
Confidentiality

The teenager's need and quest for privacy are intense at this stage of development. Given the sensitive, intimate nature of the health service sought, the patient's embarrassment is heightened. Once parental involvement is refused, the teenager should become the primary patient and confidentiality should be respected.

In an English incident, a physician informed the parents of his 15-year-old patient of his prescription of oral contraceptives. The physician was charged with professional misconduct in breaching the girl's right of privacy in medical treatment. On the special facts of that case, the doctor narrowly escaped disciplinary censure. However, the British Medical Council made it clear that future physicians who breached a patient's confidence would be liable to face an adverse ruling and its

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attendant consequences.¹¹ The development of “hassle-free” clinics underscores professional recognition of this need. One physician commented to me that in his experience, his patients eventually do inform their parents of their birth control methods. He explores with them “what if your mom happens to find your pill-pak in your drawer?” and counsels both parents and child as necessary.

Confidentiality must be set aside where there is a diagnosis of venereal disease. All provinces have laws regarding the public health and interest where such communicable disease is found or suspected. Reporting to the designated health officer only is required by law under these statutes. Otherwise, the Acts usually require stringent confidentiality from all those working in this area.

Some provinces specifically require that parents must be informed where the patient with V.D. is under 16 years. This requirement exists to ensure compliance with treatment and follow-up care. It is significant that the reporting requirement falls primarily on the physician or the nurse following specific orders from the physician or medical officer of health.¹²

Teenagers DO need contraception prescription and counselling. Withholding contraceptives from young persons is certain to result in unwanted babies, high rates of illegitimacy and blighted young lives. The nurse has a unique role in assisting and counselling young persons in need of these health services. To this end she requires skills in human relations and counselling techniques regarding human sexuality and birth control. Although the possibility of legal liability does exist, it is hoped that given the pressing need for such services in the interests of the health of Canadian youth, any Court in assessing such an action would take a progressive, liberal view in its decision.

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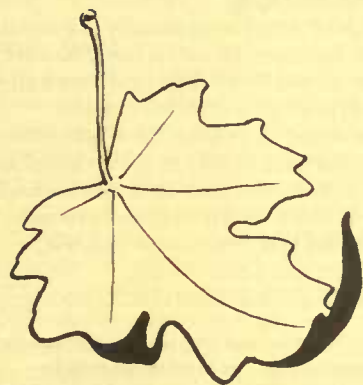
“You and the law” is a regular column that appears each month in *The Canadian Nurse* and *L'infirmière canadienne*. Author Corinne L. Sklar is a nurse and recent graduate of the University of Toronto Faculty of Law and is currently articling with a Toronto law firm.



Dying in Hospital

The dying patient confronts those of us in the health profession with a dilemma more pronounced today than ever before. Most people die in hospital, an unfamiliar environment away from the comfortable surroundings of home. In order to meet the challenge of caring for these patients, we must take a closer look at our attitudes and come to grips with our own fears about death and dying.

Janet C. Kerr



Before urbanization and industrialization were accomplished facts, death was an accepted and acceptable part of life. The individual assumed that he would know when his time had come, because most diseases had fatal outcomes. But times have changed. In our society, attitudes towards death and dying are extremely complex, and strongly characterized by denial.

Today death is often considered the ultimate failure of medicine to cure disease. No longer seen as an inevitable event of some significance, it is viewed as the unnecessary consequence of a particular disorder. It is for this reason that the occurrence of death becomes an embarrassment for those who presumably could have altered the course of events.

Medical science in our time is seen as the means to ward off disease and death. We as health care professionals are socialized to the cure phenomenon, so that our inability to cure spells defeat. The dying patient confronts us with our failure to cure illness, and his deterioration is a constant reminder of a personal failure that makes communicating with him most difficult.

"Death, that familiar companion of yore, has disappeared from our language.."

The difficulties that we face in relating to the dying patient center on our denial of death as a fact of life. Nurses and doctors are influenced by the same values and conventions as other members of society and caring for dying patients often stimulates personal anxieties about dying and an overwhelming feeling of helplessness.

Caring for dying patients

In a society where death stimulates denial and anxiety, it is hardly surprising that those who are responsible for the care and management of dying patients often perceive themselves to be caught in a particularly difficult situation. In one investigation, 40 patients with terminal illnesses were observed in order to record and evaluate their dying behavior. It was found that the patients themselves were far more at ease than those around them: "Dying behavior was not in itself uncomfortable...subjects seemed to regard death as part of the natural evolution of life, and the dying behavior itself was experienced as comfortable and even pleasant."³ Staff/patient interactions, however, were reported to be tense and uncomfortable.

"The primary paradox is that while man recognizes that death is universal, he cannot imagine his own death...It is other people who die."²

In a study designed to find out how hospital nurses cope with death, Quint reported that most of the nurses in the study group did not enjoy their assignments with dying patients, and said that they felt ill at ease talking to a dying patient, especially if the conversation turned towards his death or related matters.

Quint's study also attended to an issue of great concern to nurses — disclosure of diagnosis to the patient. The comments of one nurse gave voice to a concern shared by many: "The doctor did not tell her that she had cancer, because she is such an emotional person and he was afraid it would upset her and he thought that she would go at any moment. He told the girl at the desk that the nurses were not to

*tell her. But she had read quite a few of these cancer pamphlets, so she had a good idea that she had cancer. She would ask the nurses these different questions. Here you have a fight between the doctor who doesn't want you to tell her, and the patient who wants to know, so where do you talk first?"*⁵

In such a situation, the nurse must not only deal with her own feelings and those of the patient, but must also try to cope with the conflicting expectations of the physician and the patient. A view in favor of adopting an open approach is now shared by many of those who confront the issue on a day-to-day basis. Opinions aside, it is evident that nurses and other hospital personnel face difficult decisions as they interact with dying patients.

"Fear of death is not an immediate event, but rather a reflection about man's helplessness."⁴

"To tell or not to tell is seldom a question. Contrary to popular expectations, to be informed about a diagnosis, especially a serious diagnosis, is to be fortified, not undermined."⁶

"Those most willing to tell the truth are those who believe that there is another hope for these patients and that they can be helped to look reality in the face with hope and courage."⁷

The consequences of death-induced anxiety on the part of the staff become more serious when the behavior of dying patients does not conform to their expectations. When a patient fails to adopt the socially acceptable pretense that nothing is happening to him, he runs the risk of finding himself avoided and isolated. The staff may respond to their feelings of discomfort by labelling the patient and acting according to the meanings that they assign to his behavior.⁸ The result may well be a series of interactions clouded by the conflicts, fears and anxieties experienced by staff members as they care for the patient.

One author sees an explanation for the difficulties experienced by staff and patients in the fact that death in an institution becomes a "technical" rather than a "moral" process.⁹ This change has occurred in the wake of the knowledge explosion and the miracles wrought by advances in medicine and science. An illusion has been created, the illusion that death is obsolete.

If death is viewed as a "technical" process, it follows that the basic relationships between people also undergo a transition from "moral" to "technical". The responsibility for the care of the dying patient is now based on contract with hospital personnel rather than duty by family members. When a dying patient is admitted to hospital, it is for technical care of his physical self. In our enthusiasm for the scientific, we have emphasized only what can be done

for the body. When death is imminent, we understand it as physical death, forgetting about the human being who is in the process of dying, a moral rather than a physical or technical process.

Differential treatment

There is some evidence that the treatment accorded to dying patients who are brought in to hospital emergency departments is conditioned by age and class distinctions. Sudnow cites a case concerning an elderly person who was brought to a unit shortly after a child was treated for similar symptoms. The child had been treated aggressively; every attempt had been made to revive him, but the elderly patient "...was almost immediately pronounced dead, with no attempts at stimulation instituted. A nurse remarked later in the evening: 'They (the doctors) would never have done that to the old lady (attempt heart stimulation) even though I've seen it work on them too.'"¹⁰

After a detailed study of the evidence, Sudnow reached the conclusion that older people, those who were not well-dressed, those with the smell of alcohol on their breath or those otherwise perceived to be of "low moral character", were likely to run the risk of receiving less than optimum emergency medical treatment in hospital.

Euthanasia

This "less than optimum" treatment constitutes a form of passive euthanasia whether or not staff are conscious of their actions. It is practised by hospital personnel in those cases where the individual being treated is perceived to be of comparatively low social worth.

Guttman¹¹ comes to terms with the issue of withholding treatment for children who have abnormalities which, untreated, are incompatible with life. Acknowledging that nursing and house staff on pediatric units hold attitudes that favor the preservation of life at any cost, he suggests that efforts must be made to help staff to understand all the implications of such a policy for the child, his family and society. He advocates that full information be given to parents so that they will be better able to make a decision based on knowledge of the diagnosis, prognosis and other factors which would affect their lives and the life of their child. Perhaps the greatest need is for open discussion of the issues among concerned parties in order to facilitate informed and responsible resolution of crises of this nature.

The issues involved in passive and active euthanasia are just as complex, just as subject to value judgements, with respect to the treatment of adult patients. Although there have been some recent signs of change, almost all organized religions condemn active euthanasia.

Writing from a Christian viewpoint, Saunders¹² reflects that "Most of us can undoubtedly recall patients whose death we would like to have seen hastened, but it is my belief that if we had taken such action, we would have assumed a responsibility which is not ours."

Others assert that each situation must be treated individually and advocate collaboration between everyone involved; "...decisions relative to the dying process of a chronically ill aged patient are not made in a therapeutic vacuum...the institution should retain — indeed has an obligation to retain — a clear commitment to maintain life and function. It has no obligation to become the agent of the patient, the family, the physician or other individuals in shortening the lifespan."¹³

It seems clear that the issues are just beginning to come to light as we discuss more openly all the implications of our actions.

Communicating

Goals of care for terminally ill patients may vary considerably, but it has been pointed out that "technical" care alone is not enough — that we must be competent in treating the whole person. If dying with dignity is to be valued as a legitimate objective, then it is necessary for us to try to discover and promote attitudes and practices which will support this aim.

"...it is not enough that we do a technically competent job...we must do an equally competent job of safeguarding his dignity and self esteem."¹⁴

It has been noted that the imminence of death seems to provide the patient with additional strength to face the situation in the presence of positive and meaningful relationships.¹⁵ Glaser and Strauss have suggested that the nature of a patient's response to dying is conditioned by the way in which his prognosis is communicated as well as the subsequent behavior of nurses and other hospital personnel.¹⁶ Another author has advocated for some time the benefits of structuring the patient care environment in such a way as to promote physical and psychological comfort through pain control measures as well as a positive and sensitive approach to patients on the part of the staff.¹⁷

Involved in this sensitive approach to patients is the use of non-verbal communication, specifically through touch. Kübler-Ross¹⁸ has concluded that once the terminally ill patient has reached the acceptance stage of illness, communication is more non-verbal than verbal, that touch provided a very meaningful form of communication in moments of silence.

A survey of 900 hospital personnel, involving two general hospitals and 540 patients, concluded that registered nurses touch patients almost twice as often as other personnel.¹⁹ It was found that patients in good and fair condition were touched 70 percent more often than acutely ill patients, the latter being defined as those in serious condition with a questionable prognosis but with a chance for improvement. It was suggested that the reason for this was that health team members were afraid of death and found it difficult to provide the necessary emotional support.

Another investigation²⁰ into the therapeutic use of touch concluded that it is possible for nurses to establish meaningful communication with seriously ill individuals within a relatively short period of time through touch. Although the use of touch is only one aspect of non-verbal communication, understanding its effects in the care of seriously ill patients is at least a beginning in forming more effective relationships.

Looking ahead

It is impossible to look at the issues surrounding death and dying without considering the involvement of the patient and his family in his treatment. The traditional hierarchical authority in the hospital as well as the professional socialization of health care professionals have historically led to limited participation of this nature. Recently, there has been a movement to accommodate this need within the hospital to allow for a more humane and satisfying course of care and treatment.

In the past, curricula in nursing schools, medical schools, schools of social work and others have avoided dealing with the psychosocial aspects of caring for dying patients and their families. For this reason, practitioners have been inadequately prepared to cope with the complex issues involved, issues such as the right to know, the right to die and the responsibilities involved in euthanasia.

In order to care for those who are dying, we must be more open in our discussion of the ethical issues implied in treatment alternatives and the quality of care provided to the terminally ill. We must develop educational and evaluative strategies to assess the responses of dying patients. And from there we must pursue the development of helpful approaches that will help us meet the needs of dying patients and all the challenges involved.

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Death and dying: a personal perspective



Gail Donner

I was about twelve when my father became ill and although at that time we were not told the nature of his illness, the atmosphere in the family led all four of us children to perceive it as a serious matter. In those days, mother going out-of-town to be with father while he had surgery and staying with him for awhile afterwards was enough to indicate that something was going on. It wasn't until many years later, when we were quite grown, that my parents told us that father had had cancer and that, in fact, his survival these many years had been viewed by the medical people involved as something of a miracle.

That illness, despite its having been kept secret, was significant in terms of our later family life. Afterwards, there was always a kind of mixed message atmosphere that said, on the one hand: "Take a chance, what have you got to lose?" and, on the other hand: "Don't plan, there's no sense in making changes, etc." To this day I see myself as a rather paradoxical mixture of risk-taker and conservative, an observation that my friends and family who know me well, will support.

Now, many years later, I wonder whether the effect of my father's illness and potential death was what led me to choose nursing as a career. Perhaps it also encouraged my brothers to become involved in the helping professions. I know that these experiences, often more feelings than actual events, have influenced me greatly as a nurse in my relationships with clients.

Understanding the significance of our own personal experiences and feelings about death is an important part of becoming a "caring" person. If we have already confronted the inevitability of our own death and are prepared to relate to and to make use of our past personal experiences in coming to terms with death, we can be "there" for the dying patient in a human way that says "I too will need one day and I too have been needed". But, in order to integrate the professional in us and all the accompanying skill and expertise with the person in us and all the accompanying experiences and feelings, we must know who we are. Why do I work on a unit with the terminally ill? Why don't I? Why do I seek out all the available literature on death and dying? Why do I avoid that literature? The exploration of these and other related questions cannot help but aid us in our professional work.

A number of years ago when I was a graduate student I had a paper to complete over the Christmas holidays. I was to review the family therapy I had been doing with a family dealing with the crisis of the impending death of the mother in the family. I went home over the holidays to visit my own and my husband's family and while we were there my father-in-law died unexpectedly. I had to complete the paper and despite a great amount of guilt sat down at the typewriter a couple of days after the funeral and proceeded to work on it. I felt that I was able to use what I knew intellectually to help me deal with my feelings and that my feelings also helped me very much to deal with that paper on the family.

Knowing that there is such a defense as denial and how powerful it can be aided me greatly in coping with the many feelings I was having, helped me complete the paper and indeed made it easier for me to confront and terminate my relationship with the client family.

As nurses, we are accustomed to being with our patients and their families throughout most, if not all, phases of health and illness and, because this is so, most of us have developed special skills in the areas of crisis intervention and assisting clients and their families to deal with death and the grieving process. Nurses generally have come to assume leadership roles in these two areas, contributing to the development of theory as well as applying theory to practice.

Many of the skills that we use when dealing with the dying are skills which come from the crisis intervention model. Crisis theory offers a way of looking at experiences, assessing them and then implementing a series of approaches. Crisis intervention is short-term, goal-directed and involves the concentrated efforts of client and therapist. It is an approach indicated for individuals and families faced with sudden loss of ability to cope with a life situation. The goal is resolution of the crisis and the therapist's role is active and direct. Techniques are varied; flexibility, creativity and an individualized approach are the rule rather than the exception.¹

The approaches used in the care of the dying and their families also use a crisis intervention approach. Elisabeth Kübler-Ross, best known for bringing the need for more involvement in the grieving process of clients to the attention of professionals and lay persons as well, has contributed greatly in assisting nurses in humanizing and individualizing and thereby improving their care.² Since Kübler-Ross' pioneering efforts there has been a proliferation of articles and books aimed at helping professionals in this

long-neglected area. Some of the literature focuses on the client, some on the family and others on the helper. All of it, however, seeks to help us look at why we've ignored death and dying for so long, what the dying individual wants and fears, how to help the family and most commonly, how to assess where the client and family are in the grieving process and how to intervene to assist them in coping.

The notion of death as a crisis is not new. It is my contention, however, that it is the way in which death has been defined as a crisis which is now preventing us as professionals from further growth and skill in assisting our clients. In the literature, and thus in our intervention, death is viewed as a situational crisis, i.e. as an unanticipated event like the loss of a limb or the birth of a premature infant.³ If death were seen and indeed classified or assessed as a developmental or maturational crisis, i.e. as something which happens to all of us, like adolescence and middle age, then I believe we could move to a more advanced stage in our "helping".

Up until now, we have taken the theory and advice of the experts and have begun to master the process of assisting the client to cope with the crisis. If we could begin to look at death as a "normal" crisis, it might help us to remove some of the distance between the client and ourselves. "Death can be very hard to face, and we might be tempted to avoid it and flee from having to confront it. But if you have the courage to deal with it when it comes into your life — to accept it as an important and valuable part of life — then, whether you are facing your own death, that of someone in your care, or that of a loved one, you will grow."⁴ That is what we wish for clients and what we must cope with in ourselves. If we view death as a crisis that all of us must face we will be better able to help our clients as they go through the grieving process.

Early this year my mother-in-law died and this Summer cancer has once again reared its head in my extended family. I can't help but wonder whether that isn't why I've chosen this particular time to complete this paper that has been sitting on my desk with so many others for the better part of a year.

While this kind of reflection doesn't provide all the answers, I feel it adds an extra dimension to me as a person and much to me as a nurse. It also reminds me of the complexity that exists in people and that clients must not be reduced to stages and phases and diagnoses, but must always be seen in the context of their relationships with their significant ones as well as with their nurses and other helpers.

Nursing is a caring profession, a person-to-person one. Death is a personal experience and one which clients and their helpers can and must share. If we begin to view death in a new perspective as a developmental and natural crisis rather than a situational and unnatural event I am confident we will make further strides in our own personal growth as well as in our professional caring.

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H O P E

a negative force ?

Susan Duncan Patricia Rodney

"We read the world wrong and say that it deceives us."

Tagore

Between the third and fourth years of our university nursing program, we entered upon what was to be a unique clinical experience. We had the opportunity to work in an active treatment cancer hospital — a prospect which both fascinated and frightened us.

We knew that cancer patients at the hospital received advanced and extensive treatment regimes including chemotherapy, radiotherapy and blood transfusions. In addition, research was ongoing to evaluate the effectiveness of the treatment. At the same time, we were well aware that cancer ranks as the third highest cause of death in Canada.¹ During our months at the hospital we expected to be confronted with dying patients and their families.

We were surprised then to learn during our orientation to the hospital that "very few patients die here". That was what nursing administration said to us. In spite of this affirmation however, it was our experience that many patients did die over the course of that summer.

Working with dying patients stimulated us to examine the complexities within this particular patient care setting. We developed a conceptual framework or "system of ideas" around our experience which we feel can be applied to other care settings where patients are terminally ill.

Conceptual framework

From observing many nurse-patient interactions during our clinical experience, we became aware of the conflict that exists between nursing's orientation to patients and the reality that patients do die. We identified this as a "hope for cure" or "hope for life" orientation arising from the advanced treatment many cancer patients receive.

Hope is defined as "the state or quality of mind in which one expects confidently that what one desires will come about".² Certainly, hope can be a vital force in many patient care settings — for example, in the surgical patient whose recovery is facilitated by his expectation of an imminent return to family and friends. However, in our particular work setting, the conflict between the hope orientation and the actuality of patient death was marked and rarely contributed to the well-being of those involved in the care of the dying. In fact, it is our belief that this conflict hindered the nurse's ability to accept the reality of her patient's death.

This hope orientation seemed best epitomized by the frequently repeated statement, "We can help you." Where does this statement come from? As previously mentioned, nurses were told that patients came to the hospital for treatment and not to die. Therefore, the hope philosophy of the institution on the one hand and the reality of mortality rates on the other, strongly indicated a lack of understanding and a consequent diffusion of goals.

This inconsistency or state of conflict between two mutually incompatible response tendencies has been called cognitive dissonance.³ The response tendency of a "hope for life" communicated by the statement "we can help you" is incompatible with the reality of a cancer patient's impending death.

Nurses' needs

Any nurse who works closely with a dying patient needs time to grieve.⁴ Just as a patient goes through the stages of death and dying, so the nurse needs to progress through the stages of grieving. However, if all the time she has with the patient is focused on "hope for cure", grieving becomes impossible for her. In accordance with Dr. Kübler-Ross's framework, we focused on acceptance or nonacceptance of patients' deaths. Nonacceptance is perceived as incorporating the stages of denial, anger, bargaining and depression.⁵ For example, how many of us have felt angry with the constant presence and/or endless questions of a dying patient's family? Or how many of us have experienced depression to the point of being reluctant to enter the dying patient's room and not understood why? In our opinion, the inability to fulfil the hope of sustaining life makes it much more difficult for nurses to accept the patient's death. Nurses will see themselves as having failed in their care of these patients.

To be able to accept the death of a patient, a nurse must be able to dispense with the cure orientation. But in an environment that stresses hope to the point of denying that death will occur, nurses need help to come to terms with the fact that patients are dying. Recognition of the pressures placed on nurses by disparities between the philosophy of the institution and the realities of practice, indicates that it is time institutions took a good look at their philosophies and goals of care.

Institutional cognitive dissonance

The cognitive dissonance that exists within active treatment cancer units also exists in many other patient care settings. Intensive care units are prime examples. When the goal of "sustaining life" becomes the *raison d'être* of a unit, this may contribute negatively to the concept of total nursing care. For instance, in the neonatal intensive care unit, it is often difficult for nurses to spend time with the sick infant's family.

Statements such as, "That mother is here all day and night. She's driving me crazy", are often heard. With all her actions geared towards sustaining the life of the child, the nurse experiences dissonance over the possibility of the child's death. To listen to a mother's concerns, questions and fears of what might happen to her infant can become an overwhelming experience — one which many of us would rather not face.

Many of us have witnessed the impact that the presence of a terminal patient can have on an "active treatment ward" and consequently on the nurses' ability to provide optimum care. A woman patient, dying of uremia on an active surgical floor, for example, elicits comments on the part of the nursing staff such as "I don't know what she's doing here". Often, narcotics to relieve this patient's pain are slow to arrive.

In this kind of setting, as in many others, the nurse needs the support of her institution in order to focus on priorities and to provide better care for her dying patients.

Conclusion

We believe that hope can be a negative force in nursing care institutions. It is our feeling that institutions should examine the role that "hope for life" plays in their goals and then begin to identify the sources of cognitive dissonance. Institutions must recognize that while nurses work more closely with the dying patient than other health professionals they require support in order to function effectively in their position.

We suggest this support may take on many forms including seminars, workshops, lectures and individual counseling. Thus, provision is made to enable the nurse to accept the reality of her patient's death and provide optimum care during the last stages of life.

If nurses are to provide the best possible care to their dying patients, the barriers created by institutional dissonance must be removed. Nurses have to be helped to cope with their own frustration when hope fades. Nurses need to grieve!

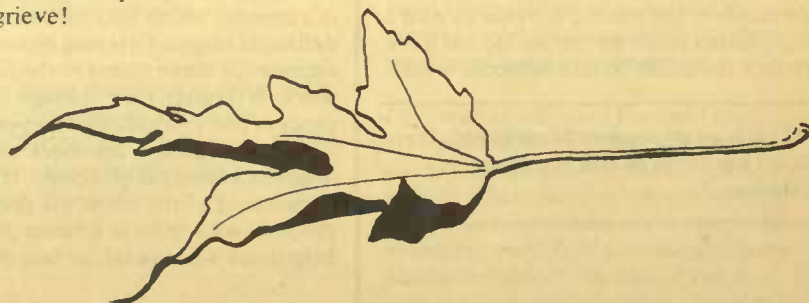
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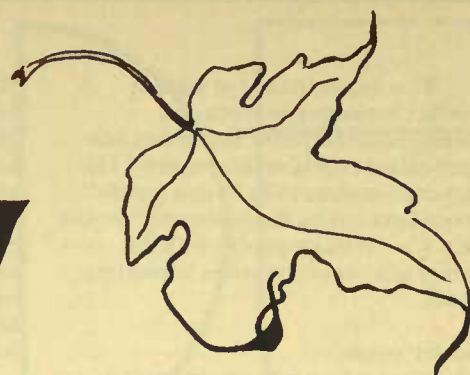
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Death in emergency



When death occurs in emergency, it is most often sudden, traumatic and unexpected. As nurses, we may be caught up in the drama of immediate life saving measures, forgetting the relatives and friends who wait just outside. But an important part of our job is to be sure that they too receive the support they need during this critical time in their lives.

Jill Courtemanche

Death is not a stranger to the emergency department. The majority of victims of fatal myocardial infarctions, the number one killer of North American adults, die on the way to hospital or in the ER. The same is true of accident victims, both adults and children. Despite the large numbers of deaths seen by emergency personnel, however, this topic is invariably absent from emergency department inservice education programs.

There are various reasons for this. Schedules for inservice in a busy ER are difficult to arrange and the amount of material to be covered is enormous. An unconscious reason may be that the subject is considered "depressing"—an uncomfortable reminder of our own mortality. Perhaps those nurses who are better equipped to face death with patients and their relatives have chosen to work in areas where they can contribute most—in oncology clinics and geriatric units. In these areas, staff are repeatedly called upon to support and prepare the dying patient and his family. In emergency, it is easy to ignore this aspect of care. The immediate medical demands of the patient provide us with a legitimate escape so that we do not have to face the death on an emotional level.

"This is an emergency department. We don't have time to talk to a dozen relatives."

The deaths we see in emergency are usually traumatic, sudden and unexpected. In most cases, the patient and his family are completely unprepared. Rarely does the person in emergency die with dignity. And often, the friends and relatives are excluded from what is going on until it is all over.

As emergency nurses, our energies are focused on "saving" the patient, a patient about whom we know very little. This patient is actively "worked on" until someone calls a halt and accepts defeat. When death occurs, we may in some way feel a sense of failure—we didn't get to him in time, we didn't administer the drugs quickly, the mechanical devices just weren't enough.

Given the nature of death in the ER, there is little we can do in the way of psychological support for the patient himself. There is, however, a great deal we can do for the survivors who in the event of a patient's death, should themselves be considered our unofficial patients.

Most of us are aware of the stages of dying as described by Dr. Kubler-Ross, but we may not be as familiar with the stages that the grieving relatives and friends go through. Like dying, grieving is a process which may be described in definable stages. Grieving persons experience these stages in the course of working through their feelings of loss, a process that can take up to a year.

In emergency, the shock of a sudden death to a family is profound. If we understand a little about the grieving process, we will be in a better position to help those who are left to face the death.

Stages of grief

1. Shock and disbelief

This is the immediate response to the news of the death of a loved one or a friend. The reaction will be all the more pronounced in the case of sudden, unexpected death. An example will serve to illustrate this point.

A few years ago, if a patient was obviously dead, ambulance drivers would radio ahead to the ER to have a doctor meet the ambulance at the door. The doctor would pronounce the patient, and the ambulance would proceed directly to the hospital morgue bypassing the emergency department.

This practice, which has now ended, posed problems for the relatives. They were unable to understand why the patient was not being rushed into emergency even though they knew he had not been breathing for a considerable time. They were too shocked to believe the obvious.

2. Stunned

This second stage of grieving seems to serve as a breathing space. The bereaved person shuts out all conscious knowledge of the death. The intensity of this stage may vary considerably—from the person who sits and stares to the person who appears to be carrying on "business as usual". This "normal" behavior is automatic, however, and is often a sign that the person has accepted the death intellectually but not emotionally. This behavior in no way reflects the depth of caring or loss, but can be seen as a way of coping.

I remember a family who had a child being kept overnight for observation and during that time, the parents were informed that their only other child had been tragically killed. The father was obliged to identify the body which was grossly mutilated. For the sake of the ill child, however, both the father and mother were able to behave in a normal if subdued manner all night and forestall the next stage of grieving.

3. *Acute anguish and despair*

During this stage, the bereaved person becomes acutely aware of the reality of the death and experiences the anguish of loss. Some people reach this stage of grieving almost immediately; others wait until they are alone. The way an individual will express this pain will depend on his cultural norms. Some societies demand loud expression of grief while others expect restraint. This stage may also give rise to physical manifestations such as hyperventilation, weakness, shortness of breath, epigastric pain, constriction of chest and throat and difficulty in swallowing.

4. *Anger*

This stage may or may not be seen in the ER. The grieving individual may express anger outwardly towards those he feels are responsible for the death including the doctors and nurses, or he may exhibit self-destructive behavior. It is not uncommon for relatives to injure themselves when they feel overcome with grief.

The final stages of grieving—*acceptance and resolution*—are the culmination of the healing process. The person has worked through the loss, despair and loneliness to come to terms with the death and continue on with living. But this takes time; generally, these stages would not be seen in the emergency department.

How to help

Helping bereaved relatives and friends is never easy—and is all the more difficult in the case of sudden, unexpected death. Often, we can be feeling badly about the person's death and sometimes we hardly know what to say to those who are left. But some thoughtful planning beforehand will minimize the strain on both the family and on us, as nurses.

"His wife was so upset. She just sat there crying and crying. I just didn't know what to say to her."

Privacy

Every emergency department should have a special place for the friends and relatives of seriously ill patients, apart from the regular waiting room. The ideal room would be within easy reach of the resuscitation area and have an outgoing phone, chairs, couch, ash trays etc. Keeping in mind the stages of anguish and anger, the room should be uncluttered and free of dangerous objects.

The importance of having a private place for the family was brought home to me on at least two specific occasions. One father, on being told of the sudden death of his child in emergency, threw himself down and beat the floor with his fists and feet. In another case, a woman who was hemorrhaging from a massive head injury was rushed to hospital while her husband held her head on his lap. When informed of her subsequent death, he went tearing through the emergency department screaming out his grief. Dressed in blood stained clothes, he alarmed the patients, visitors and those of us trying to help him.

People who are grief stricken may act irrationally. Actively seeking out a private place where they can grieve—in whatever way they feel they must—is the action of a concerned and caring nurse. Obviously, many hospital emergency departments do not have the ideal facilities. But usually there is some quiet place that can be used for this purpose.

Another concern in the area of privacy is the open discussion about a patient and his family that sometimes occurs among staff members. All staff are aware of this, and indeed legally and ethically nurses are obligated to maintain confidentiality. But in serious cases, or those involving some element of wrong-doing such as child abuse, hit and run, rape or murder, it is difficult not to "shop talk". Needless to say, it can be very distressing for relatives and friends to hear a loved one discussed clinically in the hallway, coffee shop or waiting room. It is so easy for misunderstandings to develop. Remember too, that names are not necessary for individuals to realize who is being discussed.

Communication

Preparation of the family should begin once the nurse suspects that a patient is seriously ill. Speaking with the family as soon as possible and explaining the seriousness of the situation will give the family a chance to prepare for the possibility of death. This will also give them a chance to call their own doctor, clergyman or relatives. Your own personal preparation should include some knowledge of the practices of the major religions. You would then be aware, for example, that a Jewish family would not want an autopsy.

Resources

There are many resources to draw from, both in the community and in the hospital, that can be of help to the family at this time. You should make as much use of them as possible.

Family members or friends—There are always a number of questions that must be asked about the patient, and this can be very upsetting to close family members. If possible, rather than asking the immediate relatives, talk to an intermediary—a close friend or less involved family member. They can answer some of your questions and provide you with other information so that you do not need to distress the grieving husband, wife or parent.

On one occasion, a young child had died in emergency. I asked a close family friend if he thought the family would like a Catholic priest to be called. He looked stunned for a moment and replied, "Good god, the father is a Rabbi." Naturally, I was glad I had not asked the distressed father this question.

"Thank god. John (the orderly) was here to help. We were so busy and Mrs. S. had to have someone to talk to. I'm so glad he was here."

Hospital staff—Unfortunately, it sometimes happens that a relative is alone, having no friends or family within traveling distance. This is often true for travelers, recent immigrants and the elderly—all of whom need a great deal of support. But there are times during the night, for example, when you and the only other nurse on duty may be too involved in resuscitation efforts to be able to spare valuable time for the relative. In these instances, help is needed and you must know who is dependable. If you know the capabilities of the people you work with, you will be able to enlist the aid of an understanding person—be it the orderly, ward clerk, supervisor or medical student. Experience, maturity and compassion are traits that have no relationship to status or profession.

Community—Relatives should not be notified of a death over the phone; nor is it wise to have them come to the hospital at once unless you can assure them that the situation is not grave. If you cannot do this, they will assume the worst and a distressed relative rushing to hospital is an accident waiting to happen. In these circumstances, you will find the police in most communities most helpful in picking up next-of-kin and bringing them safely and quickly to hospital.

Information—One of the most tragic situations in an emergency department occurs when an infant has suffered sudden infant death syndrome or crib death. Sooner or later, every nurse in emergency will face parents who have lost their baby in this way. Even if a pediatric hospital is in your city or area, parents will rush to the nearest hospital facility.

Generally, the public have heard of crib death but misconceptions and theories abound. The nurse should be up-to-date on current "crib death" research and should have material on hand which will serve to lessen the sense of guilt which overwhelms these parents. Many areas in Canada have parent associations for those who have lost a child; know the address of the one close to your area.*

Legal aspects

Every nurse should be familiar with the hospital policies and procedures to be followed in the event of a death. This will avoid unnecessary delays, embarrassments and mistakes (e.g. releasing valuables). You must also be aware of provincial regulations governing this area, for example, in what instances a coroner must be notified of a death.

Make it your business to know the coroners in your area (those who respond quickly and those who don't). Often, it will be left up to you to find one. If a family physician is involved however, difficulties can arise if you have taken the initiative and called a coroner without first consulting the physician.

Support

While it is the doctor's responsibility to inform relatives of a death, a nurse should always be present to lend support. It would be preferable if the family physician, someone who the family knows and trusts, could break the news but often this is not possible. If there is time try to notify the family physician so that he can plan to be at the emergency department to meet the family.

Touch—Always remember that touch is the most effective way of conveying comfort and caring, far better than hackneyed clichés. I remember one lady who had been told of her mother's death. She was sitting erect and isolated in the waiting room even though her husband was with her. When he left the room to get some coffee, I sat down next to her and put my hand on her shoulder. The next minute she was sobbing in my arms. Apparently her relationship with her husband would not permit her to react in this manner. With a stranger whom she would not see again, she could express her feelings more openly.

Finally, do not be embarrassed or ashamed of the break in your voice or the tears in your eyes. This will occur at one time or another and simply shows that you care about what has happened.

Drugs

In some cases, relatives or friends will ask for "something to get them through this". Doctors in emergency have individual preferences concerning the use of drugs and it is helpful to know beforehand how a particular doctor will respond to this request. A few will freely prescribe one or two mild tranquilizers. Others, however, refuse to prescribe anything, saying that legally these people are not their patients.

A number of physicians now believe that the use of tranquilizers inhibits the grieving process. They feel it is better for the bereaved person to cry now, to experience their grief and to start on the road to healing. These physicians will prescribe a sedative for the first night or two to help the person sleep and to help them withstand the pressures of the arrangements that must be made. If relatives require further help, they should see their own family physician. Some relatives may not understand why they are refused a prescription. Explaining the doctor's reasons to them will help.

Conclusion

The emergency department is a dynamic, fast-moving area of the hospital. It is a place where as nurses, we can get caught up in the whirl of new medical technology and of "saving lives"—so much so that we can forget the family and friends who are waiting just outside. Part of our work is to be aware of their needs too—to know that for them the death of a relative or friend is a major shock and that coping will not be easy.

Suggested reading material

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Monograph

S.I.D.S. 1974. Toronto, Canadian Foundation for the Study of Infant Deaths, 1975. This and other leaflets are available free of charge in both English and French from:
The Canadian Foundation for the Study of Infant Deaths,
4 Lawton Blvd.,
Toronto, Ontario,
M4B 1Z4.

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*See Suggested reading material for address.

Filling the gap when a family member is dying

The following account is based on my own observations and experience during the last few weeks of my brother-in-law's life. It is not a story of death and dying but rather of life and loving.

The story begins during one of my visits to see Ivan who was dying of cancer. He was in a four-bed ward in hospital. While sitting beside his bed I was overwhelmed by an urge to protect him from the cold, impersonal atmosphere of the hospital. The nurses would periodically peek in, smile and scurry away. I wondered if they were afraid I'd ask them a question they didn't want to answer.

Ivan had been in the hospital for quite awhile. By now his family was bewildered and frightened by all that was happening. The hospital was 60 kilometers away from Ivan's home. My sister and her family drove that distance every day to visit for as long as they could and then returned home. The driving and the tensions of each visit left them exhausted but, once home, they could not help but feel they should have stayed longer. Ken, Ivan's 20-year-old son, could not cope with his own feelings of despair and helplessness. Ken's discomfort kept some of the visits short and this heightened his sense of guilt.

As I fed Ivan his lunch I kept asking myself, "Why can't he be at home with his family?" If Ivan was at home, in familiar surroundings, maybe he would be less confused and disoriented. I was sure he would feel safer and definitely not as alone. He could see his grandchildren. Mary wouldn't be driving that long distance everyday and she could make all of his favorite foods.

I was sure that Ivan's family could help him. I believed also that given support and guidance they would grow and cherish the experience.

Guiseppina Roline

What is the role of the family when terminal illness strikes? How can we help them cope with their anxiety and grief? Sometimes the answer can lie in helping them act out their love and support during the patient's last weeks.

When I first suggested my idea to the family they were reluctant and frightened. Most of all they feared the unknown — "What would we do if something happened?" "Could we really care for him?" We talked about it and they soon came to realize nothing could happen to Ivan at home that wasn't already happening.

On September 25 Ivan left the hospital and went home.

Another sister, Lorraine, and I (both registered nurses) outlined a care plan for the family to follow. During the next two weeks Mary and her family proved themselves to be one of the most efficient nursing teams I have ever seen.

The family organized their days around Ivan's needs. Mary kept Ivan comfortable and made sure he had enough to drink. Ken became a pillar of strength — mentally, emotionally and physically. He lifted and turned his dad. He often sat and talked with him, at other times he just stood in the doorway and looked at Ivan.

Ivan's daughters gave him excellent skin care and they kept his mouth and teeth clean. Sometimes his grandchildren would lie on the bed with him or play with their toys on the covers of his bed. Ivan seemed to enjoy that. He would hold their hands, look at them and smile.

Twice he talked with his family about his impending death — a topic they had all avoided while he was in the hospital.

Other relatives took turns sitting with Ivan during the night. In this way Mary and the children got the rest they so badly needed.

Ivan passed away early one morning a few weeks after he'd returned home. There were no drainage tubes, intravenous feedings or oxygen. Instead there was comfort, dignity, a loving family and God.

This experience raised an important question in my mind.

Can families be made aware of how important and needed they are when a loved one is dying? Mary and her family were totally lost in their helplessness until they were actually doing the caring themselves. Their anxiety was reduced once Ivan moved back home because they were doing something — they were giving. Ivan's family was giving comfort and love.

I am convinced the time this family spent with their husband and father filled part of the gap left in his dying.

Guiseppina Roline wrote "Filling the gap when a family member is dying" after experiencing the sickness and death of a close relative. She graduated in 1955 from the Alberta Hospital in Ponoka. Guiseppina is a registered and psychiatric nurse working in the psychiatric unit at the University of Alberta Hospital in Edmonton.

My fight for life



Linda Walker

THERE ARE A FEW EXPERIENCES IN LIFE THAT ARE COMMON TO ALL OF US. DEATH IS ONE OF THEM.

One of the hardest things I have ever had to do is live...and yet slowly die. I am a victim of cystic fibrosis, emphysema and pneumonia. They are all taking their toll, in January my doctors told me I had about two years left to live.

Cystic fibrosis is a genetically inherited disorder. While neither parent may have CF, each passes on a carrier gene. When these genes unite a child is born with cystic fibrosis. As a rule this automatically sentences that child to a very early death. Medical science has improved our chances of survival to a point where most of us will live to see our mid-teens, perhaps even our early twenties. I am one of the lucky ones. I celebrated my 23rd birthday last month.

Cystic fibrosis attacks the respiratory and the digestive systems with varying degrees of severity. Normally all of the digestive juices are produced in the body. With CF the function of the pancreas is impaired and this means a pancreatic substitute is necessary. This substitute is taken in capsule form. I take four capsules per meal — an improvement over the 50 or 60-per-meal required with the older drugs.

It is the respiratory problem which is the most deadly. My lungs are a cesspool of thick, greenish-colored mucus. It is a constant source of irritation, embarrassment and inconvenience. The only way to expel the phlegm is by coughing. Not a gentle, lady-like cough, but a racking, gut-hurting cough that sounds as if I smoke three packs of cigarettes a day. The coughing "seizures" usually start at the most inconvenient times — when I am talking, eating, in public, and especially when I am doing my best to be quiet. If I didn't cough up the phlegm my lungs would fill and I would suffocate. To cough is to live.

There was a time, when I was between the ages of 10 and 18, when it appeared that the CF had been arrested. It was a time of an almost carefree belief in my living a normal life. I would grow up, marry, perhaps have a child and, in later years, enjoy my old age.

Then, my dreams were shattered. I lived with relatives in Montreal for about two and a half years when I was 16. It was while I was in Montreal that the real deterioration began. I started to have slight bouts of pneumonia which, at that time, were readily cured by antibiotics.

In the fall of 1974 I returned to Ottawa to complete Grade 12. During the first month of school my cough worsened and I missed many classes. By October I was in the hospital with a full-fledged case of pneumonia. It took months for me to get back on my feet.

I completed Grade 12 that year by going to summer school. I also met Bob, the most important person in my life.

September 1975 found me no healthier than I was the year before. This time I was in my first year at a community college in Ottawa. Again I had a severe case of pneumonia which was compounded by septicemia, a blood infection. Recovery was even more difficult this time.

I decided to leave Algonquin College in the spring and attend Bishop's University in Lennoxville, Quebec. I was fortunate enough to get a summer job working in the university library. This meant I had to move to Sherbrooke at the beginning of May 1976.

I got sick again that summer. This time I was vomiting and had pains on my right side. A check-up with my CF doctor revealed that I had gallstones. My gallbladder was removed on October 21, 1976.

At this point the whole course of my life changed radically. I never completely recovered from the surgery. Testing revealed that, once again, I required the pancreatic enzymes I had been able to live without for ten years. Two particularly stubborn strains of pneumonia became imbedded deep in my lungs. My weight dropped from 48 to 39 kg. and has remained the same ever since. I am unable to gain weight because the food nutrients my body extracts are used in coughing and just plain trying to breathe.

In the past year I have been in hospital nine times. This has greatly interfered with my schoolwork. Now I find I will be unable to continue my education. The course load is beyond my strength.

I have always insisted that my doctors be completely honest with me regarding my state of health. They have always complied with my wishes and I have always known where I stand. In spite of this even I was thrown for a loop last January when both the doctors confirmed my worst suspicions. I have been told I have about two years to live, give or take a few months.

For some time before that Bob and I knew in our hearts that I was seriously ill — yes ... dying. We had watched my strength disappear. Simple tasks, like housework, became too difficult. Forget stairs — I had to be helped or carried up them. I could not walk far. Together we had seen all the signs but still we tried to ignore them.

Suddenly, with the prognosis "out in the open" everything became clear. It was time to get serious. I'm dying and believe me, it is no joke.

My first reaction was one of anger. Not at anyone, but at the illness itself — how dare it invade and destroy my life? Then I asked in despair, "Why me?" I cried a lot and did not want to be alone. One night in my hospital room I became furious and completely demolished half a dozen magazines. I sat there and methodically destroyed them. The floor was littered with paper. Then I broke into tears. My nurse came in, saw what had happened and, because she understood, said nothing. She cleaned up the mess and held me to let me cry it out. It was quite awhile before I could calm down.

Ever since my gallbladder surgery I have, when necessary, returned to the Sherbrooke Hospital. With all my experience in hospitals I have never been in one that compares with Sherbrooke. The doctors are excellent and the staff is incredible. I know virtually everyone there. When I am down and blue, there is someone to help. When I am happy, there is someone to share my joy. This is important because I am in the hospital

often and rely heavily on the nurses for support. Many are around my age and we have become close friends. I love them and I know some of that love is returned.

I have had to make many adjustments to my lifestyle in the past few years — not all welcome ones. I was always very active and now I find I am almost entirely restricted. My rest requirements have doubled, I cannot eat many of the foods I love, my cough is harsher and more frequent. I must take antibiotics to keep the ever-present threat of infection down to a minimum. I need people more than I ever thought I would. I find I am unable to carry on alone.

If it were not for the loving and caring of my family and friends I wouldn't want to live — I couldn't. At the top of the list, I must put Bob. He is everything I ever wanted in a partner and more. A lot of men would have walked out by now but Bob has stayed by my side and helped me through everything. He encourages me, comforts me and gives me a boot in the rear when I need it. After the initial shock of being told I was dying my friends rallied around. My own family, because they live 200 miles away, cannot do much but they keep in touch. Bob's family has taken me in and I am treated as one of their own. The love they give so freely has done more to help me cope than anything or anyone else. I can always count on them when I need them.

I have enjoyed crafts, reading, sewing and music for many years. Now, more than ever, I turn to these as a source of both entertainment and necessity. I cannot get up and about very easily so I need hobbies that allow me to sit quietly. I have taken up stamp collecting and photography. I photographed the wedding of Bob's brother a year ago and my brother's this July. My stamp collection is only a few months old but it's already becoming quite respectable. Many friends were kind enough to donate stamps when I started.

I have always enjoyed writing to people and correspondence plays an important part in my life. I have made many friends and I try to keep in touch with them as often as possible. The writing and replies I receive help keep me in touch with the rest of the world — a great morale booster.

At this point I am trying to think about anything at all other than dying. Life is too precious and beautiful. I'm young and in love and I try to keep happy. It is not easy by any means. How can I not be afraid when my next cough may be my last? How can I not be afraid

threatened by my body's eventual rejection of the antibiotics which keep me alive? Fear is always a part of me. So is despair, anger and loneliness. In me there is the overwhelming urge to live and perhaps fool medical science by living beyond the two years. It's not likely but I am going to try.

Now I thank God every morning when I wake up. I do believe some of my spirit comes from a force greater than life. I try to appreciate everything I do for there will be a time, all too soon, when I won't be able to do it anymore.

Other physical problems have come up as my illness has progressed. Due to the strength of the antibiotics I require, my kidneys are not what they once were. Their efficiency has become impaired — liquids are not readily absorbed. The strain of coughing sometimes tears my throat and lungs. When this happens I cough up blood causing everyone great concern. My skin is dehydrated. My periods have ceased. Physically, I am a wreck.

I have decided that I will not marry. Perhaps I never would have but now I am certain. It would be unfair of me to expect Bob, or anyone else, to be my husband. All too soon he would be a widower. I cannot fulfill a lifelong commitment. "Till death do us part" is a harsh reality.

One of the biggest disappointments I am experiencing is the fact that I will never be able to have children. Not only is it virtually impossible for me to conceive but I would never be able to carry to full term. I feel hurt and empty. I wanted so much to give Bob a child.

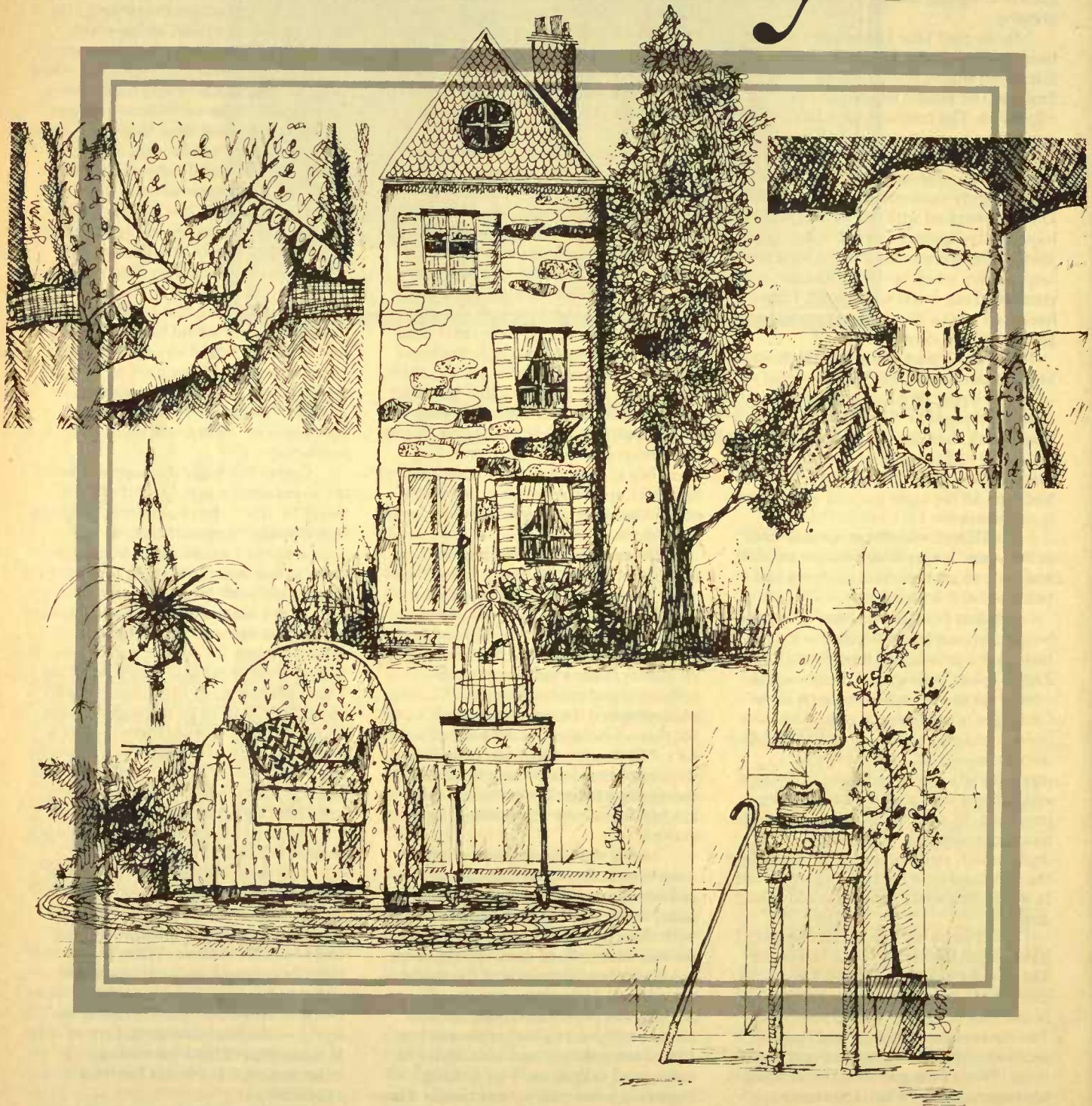
I have made arrangements to ensure my body is turned over to my cystic fibrosis doctor for research after I die. It is important to me that a cure be found. There are too many little children who should not have to go through my pain and suffering — I want them to have a chance at life and loving. I want them to have what I won't. Maybe my body will provide the clue that researchers have been looking for in order to prolong life.

Someday the average cystic fibrosis patient will live as long as I have.

I no longer dream of a future with a husband, home and children. I take life day-by-day now and hope for the best. Every hour — every minute — counts and I hold them close. When I think of what lies ahead I am both afraid and curious. I'm afraid of what death is but I'm also afraid of what it is like to be dying — the final moments. I try to look at it as a part of life I have never experienced. I know it is the final experience.

Until then, I will do my best to live and to love.

Saying Goodbye



Deborah A. Gibson

I met Mrs. Norris during my third year as a student nurse. At the time, she had been a patient in a chronic care hospital for a little over a year, sharing a room with three other women.

Mrs. Norris was an 81-year-old Scottish woman who had lived most of her life on a farm, surrounded by a large and close-knit family. The day came however, when she was so crippled with arthritis that she had to be admitted to the hospital for care. It was one of Calgary's auxiliary hospitals — I was involved in a geriatric practicum there as part of my nursing experience.

Mrs. Norris may have been restricted to a life of "bed-to-wheelchair" but that didn't keep her from her favorite pastime — she kept on knitting. I remember sitting with her in the evenings. I can almost see her, her silver hair pulled back neatly into a braided bun, and her favorite shawl pulled over the shoulders of a handsewn gingham nightgown. Often I just listened to her stories about living on the farm. As I listened, I watched her disfigured hands moving slowly to complete each of the squares that would someday become an afghan quilt. She had started the squares when she first came to hospital.

Her health was failing, and we became closer. Mrs. Norris began to talk about dying. All my feelings began to go into the care I was giving her. We had talked together so much that I was able to draw on what I knew about her and apply it in my nursing care. She had always been very proud about her appearance, and my attempts to maintain her neatly braided hair were always met with smiles and a hug. There were times when she was too weak to talk; then I would just hold her hand to let her know that we didn't always need words to communicate.

Mrs. Norris had many visits with her family, usually on weekends when they would drive the 60 kilometres to bring her company and candies. Their affection for her was warmly and openly expressed.

It was after one of these visits that she suddenly reached for my hand and said "You know dear, I'm going to die soon." My first impulse was to deny what she had just expressed. But over the last weeks I had become prepared for her death, just as she had. So I stayed with her and cautiously asked "How do you feel about it?"

Obviously she was waiting for such a response, because she smiled and said that she felt very comfortable about it. She said that her stay in the hospital, far away from her home, had given her time to think about how full her life had been. She winked at me and told me that she had met new people at the hospital who had been wonderful too.

For the rest of the evening, Mrs. Norris and I talked about death and what it meant to her. And as I was leaving her room, she called me back and asked me to get her box of afghan squares. Then she asked me to take them and put together an afghan for myself. "It's my way of thanking you," she said.

Mrs. Norris died one night later, peacefully and in her sleep, with her favorite shawl still around her shoulders.

I often remember our last talk. When I remember I feel thankful to this woman for showing me that death doesn't need to be an uncomfortable or unhappy experience, for teaching me something about being a nurse.

As I write, a beautiful afghan lies at the foot of my bed. The memory of Mrs. Norris is a part of the warm feelings I have whenever I look at it or wrap it around my shoulders.

Deborah A. Gibson, (R.N., B.N.) author of "Saying goodbye" was a student nurse in fourth year at the University of Calgary at the time she wrote about Mrs. Norris. She has been an active member of the Canadian University Nursing Students Association, both as Programme Chairman of the National Conference held in Calgary in 1977 and as Western Research Representative on the national executive. Deborah has been active as an artist as well. Her beautiful pen and ink sketches illustrate her own article as well as "Dying in hospital" by Janet C. Kerr. She was editor and art editor of "The Student Epicurean", a cookbook published by University of Calgary's fourth year nursing students in August 1977. Deborah is now a public health nurse in High River, Alberta.



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Are you a successful communicator?

"One friend, one person who is truly understanding, who takes the trouble to listen as we consider our problem, can change our whole outlook on the world."

—Dr. Elton Mayo¹

Robert Veninga

Interpersonal patient education encompasses two important objectives. The first objective is to provide vital information which patients need in order to better manage their lives. The second objective should be to give support and encouragement to individuals who are experiencing a health crisis.

The giving of information to a patient about his illness is an essential step in the rehabilitative process. What the patient does with that information will be directly related to his understanding of the material, the credibility which he places in the sender of the message and his own willingness to utilize new concepts and practice new health behaviors. Because information by itself seldom changes attitudes the patient educator's willingness to become

personally involved with the patient's perceptions and decision-making possibilities is a critical variable as to whether the information will have a positive effect on the rehabilitative process.

Interpersonal communication may be the most crucial variable in determining whether an educational program will realize its objectives. If this premise is correct, it would seem appropriate that the patient educator periodically evaluate several key interpersonal variables and determine the ways in which human communication is influencing educational outcomes.

Competency One: **Listening to what you are hearing**

As a nurse, you are also a teacher, a

source of the information that patients need in order to live better lives. If facts could be fed into patients like numbers into computers the process of giving information would be simple. But this is not the case. Effective health teaching requires so much more than information giving. It demands that you be an involved listener, one who can really hear what the patient is saying, and then help him to work out his own solutions to the problems that confront him. It begins with knowing how to listen.

The ability to listen to and understand the meaning of a patient's words is the most basic element in relating health information to the unique needs and interests of the individual. In addition to this the ability to listen to and understand the meaning of messages sent by other

professionals is vitally important in designing an effective one-to-one education program.

Recent studies show that we are not good listeners. Ineffective listening habits are perpetuated because many of us believe that listening is an essentially passive exercise. Two months after listening to a lecture most of us will remember only 25 per cent of what was said.

Nichols and Stevens discovered that, "... we tend to forget from one-half to one-third of (something we have learned) within eight hours; it is startling to realize that frequently we forget more in the first short interval than we do in the next six months."²

What interferes with effective listening patterns? Psychological noise is defined as any mental interruption which keeps us from focusing on the conversation. "Inevitably, scores of distracting stimuli turn in every listening situation. To escape them we should have to be isolated in some specially built, sound-proof room. Some of our most frequent distractions are uncomfortable temperatures, annoying speaking mannerisms, apparently dull topics, fatigue, bad acoustics, noises ... We either adjust to these stimuli, or we are defeated by them."³

There are three specific suggestions which work to improve listening comprehension.

1. Effective listening skills are closely related to a person's ability to concentrate on what is being said. At one large American midwestern university 82 percent of the students interviewed reported that the "inability to concentrate" was their main problem at school.

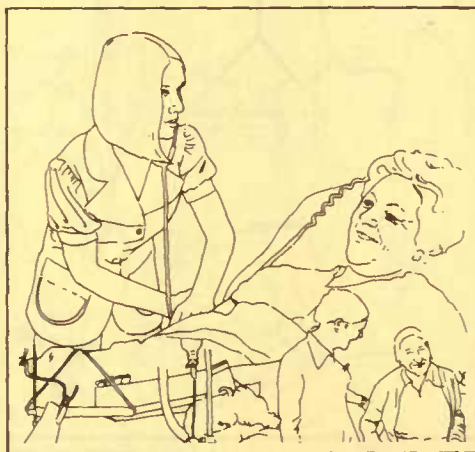
The inability to concentrate is also a barrier to effective communication in patient education. The educator who is thinking of other things (letting his mind wander) cannot accurately receive and decode messages from the patient he is teaching. The patient educator who gives each interview his undivided attention makes an important commitment which helps create a climate for effective patterns of listening and positive learning experiences.

2. The effective listener will concentrate on the conversation diligently for four or five minutes and then take a quick mental break. During this brief "time out" the listener can rephrase the most pertinent points of the past few minutes. In this way you can check to see if your perception of what your patient is saying corresponds with what they are actually

thinking. This 'brief summary' method has the added benefit of letting your patient know that you are "in-pharse" with what they are saying and feeling.

3. This third suggestion is more a philosophy than a specific behavior to be learned. If we begin an interview assuming that the patient can help us find a solution to his problem then we will be less likely to give unqualified advice. The key to non-directive counseling lies in a faith that each man is a rational being who, given the necessary information, has the potential to eventually resolve those problems which produce dissonance and discomfort.

Effective patient education means helping patients resolve problems over which they have control. A patient educator who believes patients can control their problems will listen in order to understand both the obvious and the unspoken concerns of their patient. The



educator will then, on the basis of what he has heard, be better able to give the care that is needed. Hollis pointed out, "When a person knows that he has a good listener to talk to, he'll share his thoughts more fully, which in turn, make it easier ... to help him with his problems... as he talks the person needing help often finds a good solution to his problems himself."⁴

Your patient can positively intervene in his own treatment process and this is the major reason you need to take the time to ensure your own effective listening practices.

Competency Two: Your patient's private world of perceptions

How does the old man down the hall view his growing frailty? If you are attempting to teach him self care then you should know. You should be able to understand

his illness and hospitalization from his point of view. You will never really see the world his way unless he trusts you. You will never understand his perceptions if you judge him first. How can you make your message meaningful to him if you don't even know him?

No one can enter the private perceptual world of another individual unless they are invited to do so. Your patient's own perception of being institutionalized, his perception of the care he is being given, the degree of his optimism or pessimism about the future, all of these privately held perspectives are, to varying degrees, locked within his private perceptual world.

It is important for the patient educator to discover these attitudes, values and behaviors which, although hidden from view, will influence the recovery process. The patient educator can influence, in a positive way, an individual's decision to reveal his private perceptual world. The most critical variable here has to do with whether the patient believes the educator is trustworthy and credible.

How does your patient perceive his teacher? The answer is linked to the nonverbal cues he receives. Two-thirds of the messages you send to other people are sent through the nonverbal channel. Most individuals trust the nonverbal messages they receive because they have learned that although people can lie verbally, it is hard to hide that lie nonverbally.

The patient educator who says, "I'm glad to see you" but looks out the window and appears harassed and bored with the conversation will undermine the credibility of his words. "The blush or the frown is likely to be taken as more reliable than the accompanying verbal reassurances. When verbal cues and nonverbal cues tell different stories, the nonverbal story tends to be believed. Words can be chosen with care, but expressive nonverbal cues cannot be chosen. The body is not so easily governed."⁵

It takes a great deal of effort to understand another person's perceptual world. You must be able to resist prejudging what you think you will hear or what you are hearing.

"Our first reaction to most of the statements which we hear from other people is an immediate evaluation or judgment, rather than an understanding of it. When someone expresses some feeling or attitude or belief, our tendency

is, almost immediately, to feel 'That's right' 'That's stupid' 'That's abnormal' 'That's reasonable' 'That's incorrect' or 'That's not nice.' Very rarely do we permit ourselves to understand precisely what the meaning of his statement is to him. I believe this is because understanding is risky. If I let myself really understand another person, I might be changed by that understanding. And we all fear change. So as I say, it is not an easy thing to permit oneself to understand an individual, to enter thoroughly and completely and emphatically into his frame of reference. It is also a rare thing."⁶

An understanding of the private perceptual world of your patient is made easier by direct, "out-front" communication. "You cannot collaborate with another person towards some common end unless you know him. How can you know him, and he you, unless you have engaged in enough mutual disclosures of self to be able to anticipate how he will react and what part he will play?"⁷

'Mutual disclosure' suggests that you are listening carefully enough to hear what your patient is saying and implying. It also means that you are willing to share your own perceptions concerning what is happening to your patient in his recovery process.

The sharing of your perceptions regarding the healing process can serve:

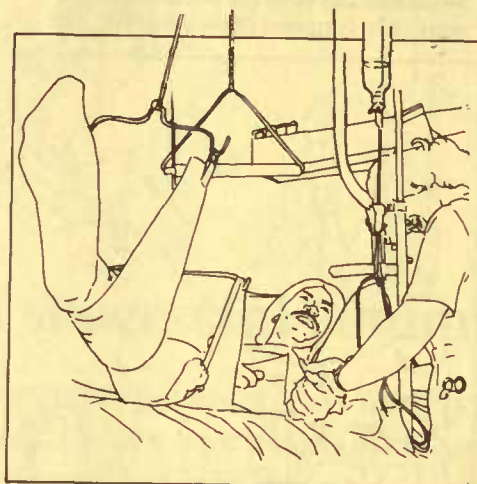
- as a clear signal to the patient that you have listened carefully to what he has said;
- to help your patient see the logical consequences of his own attitude and behavior;
- as a definitive sign that you care about your patient and that you are willing to invest time and energy in the relationship;
- to build a trusting relationship between you and your patient.

Competency Three: Resolving interpersonal conflict

When you look back at the day behind you you will very likely see that a significant amount of your time was spent dealing with struggles or conflicts with others. As a nurse, you are dealing first of all with hospitalized patients who often find their world unpredictable and frightening. You are also dealing with other staff members in a sometimes uneasy power structure. Where there is uncertainty and anxiety, there will be interpersonal conflict. This

conflict is a barrier to effective interpersonal communication and thus to patient education. If you want to teach effectively, you must be able to resolve conflict.

While it is true that all employees in all organizations become involved in conflict situations, as a patient educator you may be particularly susceptible. This happens for two reasons. First, you are relating to patients who are anxious and in a new environment. This tends to increase the possibility for misunderstanding, misinformation and disagreement. A second reason is the new emphasis patient education is receiving in the health care system. Whenever a new role is being emphasized one can expect power struggles and, therefore, conflict.



Since the environment of the patient educator is susceptible to conflict, it would appear that resolving conflict is an important skill to learn. Attentive listening patterns and a willingness to see the world from the perspective of others are significant communication skills which diminish the likelihood of tension but there are other variables involved.

The most appropriate approach for resolving interpersonal conflict recognizes that the reasons given to explain the causes of a problem are often not the real reasons for the tension. The "covert" reason must be determined if the conflict is to be understood and resolved. Your patient may give you a variety of plausible reasons as to why they do not attend your scheduled patient education conferences. But these 'open' explanations may mask the real reason which is that no individual in the clinic is bilingual and your patient does not feel comfortable with the English

language. Long-term solutions to problems can only emerge after all the reasons for the problem have been recognized.

Conflicts are often interpreted as attacks upon one's personhood. In order to effectively resolve the conflict it is important to depersonalize that conflict as much as possible. Your ability to depersonalize the nature of the conflict will influence the situation. The tension between the nursing in-service director and a head nurse over what educational programs are appropriate for the coming year may, in reality, be over the issue of who has the most power in the organizational hierarchy. The players in this situation are asking: "Who respects me? Who values my ideas? Who is seeking to diminish my power? Who is trying to get ahead at my expense?"

How do you depersonalize conflict? Used by a patient educator each of these opening statements would have a different effect. If directed at you which statement would make you feel defensive? Which would put you at ease?

Example One:

"We have been working together for three years, Sue, on patient education programs of one type or another. Generally, we have been able to work quite well together. But lately it seems we just haven't been clicking. I wonder if there are some things we could do together which might better the situation?"

Example one can be referred to as the "we-are-both-responsible" approach. If there is a problem affecting more than one person, all must be equally involved in finding responsible solutions to the problem. By asking, "I wonder if there are some things we could do to better the situation?" the patient educator is indicating her willingness to assume responsibility for part of the problem and to work toward a jointly acceptable solution. By using the jointly responsible point of view a climate of security is established and defense mechanisms are less likely to be involved.

Example Two:

"Your attitudes towards your illness will keep you in the sick bed for a long, long time, Mrs. Edwards."

Example Three:

"Mary, what in the world am I going to do with you ...?"

Examples two and three are statements arousing hostility. The typical reaction to this kind of remark is likely to be either a hostile retort or a stoney silence. Neither response is useful in working the situation through to a satisfactory conclusion.

Example Four:

"I wanted to bring those of you who worked on the last diabetes education program together in order to talk about our next program. As you know, the evaluations of the last diabetes program were not as good as the evaluation from our other programs. What do you think we might be able to do at our next program which will improve the situation?"

Example four provides what might be called a "let's-look-to-the-future" approach. The initiator (in this case the patient educator) recognizes that it does little good to blame someone for a problem and they demonstrate their interest in determining what must be done to ensure that the problem does not reemerge. This positive approach gives everyone a chance to work towards finding solutions to the problem and puts everyone at ease. The conflict has become depersonalized.

Unfortunately we often do not think before becoming involved in emotional, defensive situations. The result is that when conflict is confronted (often after days, weeks or even years of circumventing the issues) the discussion is heated and does nothing to resolve underlying tensions. While the airing of keenly felt attitudes and feelings may have a temporarily therapeutic effect, it often serves only to heighten the tension between individuals. If someone expresses their deeply-felt attitudes and no positive solution emerges then individuals leave the meeting with their defenses up, polarities drawn and resolve never again to be drawn into the open.

How can we resolve difficult interpersonal problems? First of all we must carefully define the problem and discover the private perceptual world of the participants involved in the conflict. How do they see the problem? From what vantage point? Are you dealing with the overt problem or is the discussion obscuring the smouldering issue?

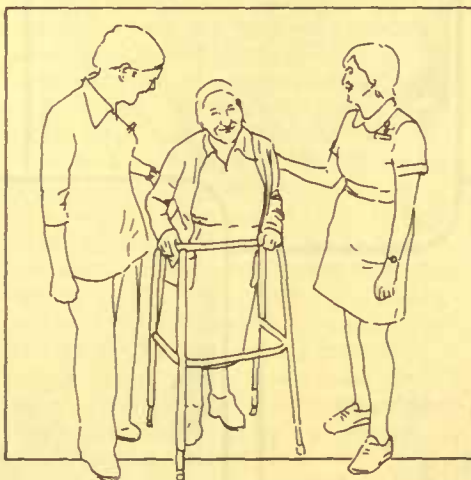
Now outline and list all of the solutions to the defined problem and evaluate the strengths and weaknesses of each solution. This should involve a systematic discussion of each solution.

Finally, on the basis of that discussion determine which is the best solution to the problem.

After you've determined your solution, put it in writing. A written agreement ensures that there is a common understanding about what is to be done to resolve the problem — by stipulating who is responsible for what and by what date, expectations are understood. Such carefully written solutions increase the possibility that your solutions will, in fact, resolve the problem.

As nurses and patient educators our role is one of teaching health information. It is a step basic to the rehabilitative process and entirely dependent upon interpersonal communication.

What your patient does with the information you give him is directly



related to an understanding of the material, his trust in you and his own willingness to accept new concepts and practice new health behaviors. It is important to remember that information alone seldom changes attitudes.⁸ Whether the information we are providing has a positive effect on the rehabilitative process depends to a large degree on our willingness to listen closely and make the effort to understand our patient's perceptions of his illness.

In summary, the effectiveness of a health education program will be directly related to the interpersonal communication that takes place between the educator and the patient. Effective interpersonal communication takes place when attentive listening patterns are present, when efforts are made to understand the private perceptual world of one another, and when depersonalized process-oriented efforts are used to

minimize disruptive conflict. Using these communication competencies successfully can help to make interpersonal patient education a reality.

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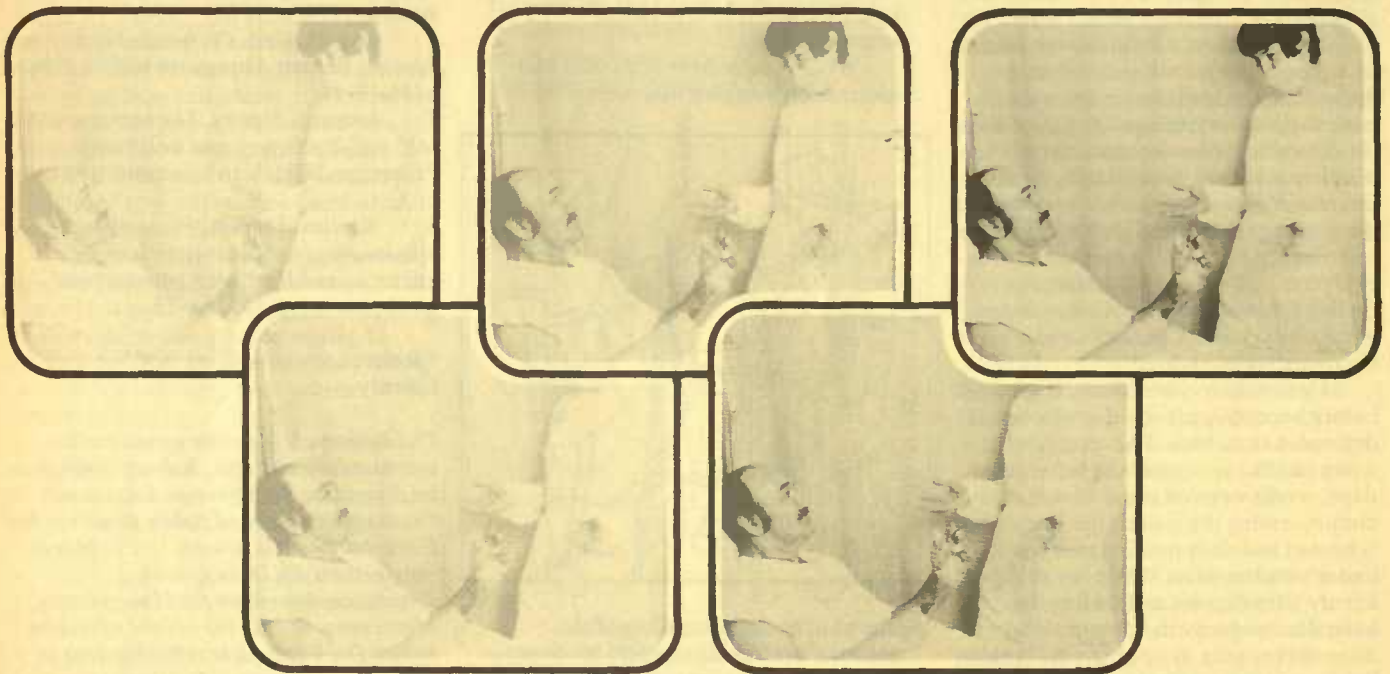
* Reference not verified by CNA Library.

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One Day at a Time on a Burn Unit

A good nurse-patient relationship is essential in helping the person suffering from burn injuries to cope with the stress of hospitalization. The first step for the nurse, according to this author, is to understand what the burn patient is going through at different stages of his treatment.



Barbara Peeling

Burns are among the most devastating injuries sustained by man. They affect an individual's psychological as well as his physiological state. When a burn occurs, medical therapy and nursing interventions are directed toward restoration and repair of tissues and in this early stage, life-sustaining measures are of paramount importance. Once these have been initiated however, it is possible for the nursing staff to attend to the psychological needs of the burn patient.

Every burn patient suffers an intense psychological response to the injury and inevitably experiences great anxiety during his hospital stay. Hospitalization means painful treatments and the stress associated with these treatments is a potential cause of anxiety for these individuals. During the course of a recent

study into the psychological reactions of the less severely burned patient, I found that treatment stress was often the cause of emotional reactions exhibited by burn victims.

Five patients, four men and one woman, with less than 30% second and third degree burns were studied intensively on a daily basis over the period of their hospitalization, which was about one month. Data were gathered by means of an analysis of nurses' notes, daily sleep and medication records and daily patient diaries. I also made eight visits to each patient and attempted to measure their anxiety using an anxiety indicator.*

*State-Trait Anxiety Inventory used during six visits to each patient.

The patients

Phil was a 20-year-old male with 15% burns to his hands, forearms and right flank. A tall, blond fellow who worked as a laborer in the northern areas of the province, he eagerly welcomed my visits as a diversion from his enforced isolation.

Bruce, a 35-year-old male, had sustained 12% burns to both calves circumferentially. A part-time artist with a labile disposition, Bruce viewed his hospitalization philosophically.

Dan was a 30-year-old male burned 26% to his hands, left forearm, back, neck and face. He was a well-built construction worker whose stoicism was uncanny. The most verbal of all the patients, Dan would relay his emotions in vivid detail during my lengthy visits with him.

Carl was a 27-year-old male with 4% burns to his right hand and forearm. A handsome, amicable chap who had just acquired a job in a broker's office, he was most eager to share his concerns with me.

Sarah was a 60-year-old female burned 10% to the anterior aspects of her thighs and perineum. This lady, younger looking than her actual years, was an avid swimmer. During my initial visits with her, *Sarah* was often aloof and suspicious. However, once a trusting relationship developed between us, she readily expressed her concerns.

Phil, *Bruce* and *Dan's* burns were caused by industrial-related accidents whereas *Carl's* and *Sarah's* burns occurred at home.

All the patients underwent the same treatments — burn baths or arm baths, saline compresses and skin grafting with subsequent rolling of the new grafts with Q-tips.* In addition, *Bruce* and *Carl* also had surgical K-wires inserted through their ankles and knuckles respectively, in order to suspend the limb(s) in traction after skin grafting.

The emotional response to the burn injury varied markedly with each patient. However, during my observations, I found that psychologically each of them passed through five phases and that certain types of responses seemed to accompany each phase. These phases were observable, were sequential in time and occurred roughly during the same periods of treatment for each patient.

Phase one

In the initial reaction to burn injury, the patients seemed to disengage themselves from the facts of the situation by using denial. They functioned as if the accident had not happened to them personally. Later on, however, they all seemed to have a need to review and analyze the events surrounding their accident and to talk about it.

For the first few days, these people were rarely troubled about the future appearance, deformity or possible malfunction of a limb. They seemed nonchalant and almost too accepting of their injury. Instead, their concerns turned outwards, towards the strangeness of the burn unit itself. They were most anxious to know about the expected length of hospitalization.

The most prominent source of anxiety for them at this time was fear of the unknown. Not knowing what to expect and lack of information about what was going to happen to them caused these patients great stress.

This was particularly marked in *Dan's* case. When he was first admitted to the burn unit, his eyelids were so swollen that he could not see. He judged the time of day by his burn bath schedule, the human traffic in the hallway and the automobile traffic outside. *Dan* showed intense concern over not knowing what was happening to him and what treatment was to come next.

Bruce seemed to deny the severity of his grossly infected burns and to belittle the pain he was experiencing during the burn bath and compress treatments. Although he seemed very blasé when I spoke with him, the nurses' notes reported that this patient was extremely anxious. Although he often showed his anxiety by hyperventilating during his treatments, he did not verbally react to the pain during this phase.

On admission, *Carl* was extremely anxious, tense and regretful. His initial concern was the proposed length of hospitalization and not knowing what was going to happen to him.

Disengagement behavior was exhibited by *Sarah* who was extremely anxious and tense on admission to hospital. Like *Carl*, her initial concern was the proposed length of hospitalization. Her reaction to the stress of tub baths and the debridement (removal of dead tissue) that followed was unusual. During this time, she would disengage herself from her environment by sleeping a great deal. The nurses' notes reported a lack of appetite and apparent confusion when awake. But as the days passed, she became more alert, oriented and her appetite increased even though she was undergoing painful compress treatments. She explained to me that by shutting herself off from her surroundings, her "body was able to catch up to her soul."

During the latter part of this phase, *Carl* and *Sarah* ventilated their frustrations about their own carelessness for the cause of the accident. *Phil*, *Bruce* and *Dan* accepted the misfortune of their work-related accidents as "fate".

Phase two

The second phase was characterized by the emergence of a latent reaction to the burn injury itself. It was marked by inappropriate emotional responses to self, staff and surroundings. In this phase, the patients seemed aware of the reality of their situation. To protect themselves from it, they began to employ defense mechanisms such as regression and aggression. Later, some patients experienced nightmares about their accident.

Phil displayed characteristic behaviors of this phase very soon after his admission to the burn unit. By the third day, he was undergoing burn baths and the nurses' notes reported that he was anxious, apprehensive and very

concerned about himself. He became suspicious of the nursing staff, requested analgesics constantly and wondered if other patients had as much pain as he did. The next day, the nurses' notes reported that *Phil* was being hostile, sarcastic, and attention seeking. When self-care and independence were encouraged, he verbally lashed out at the nurses. He felt that the staff was against him.

During this phase, *Bruce* began to realize the seriousness of his infected burn. He reacted verbally in an aggressive manner to the pain he was experiencing during his compress treatments.

Carl became concerned about the future appearance and functioning of his burned right hand. He now realized that he might not regain total function of his hand. Since he worked in an office and met the public, this was of great concern to him.

Sarah's main concern was the depth of burn to her thigh and perineum and the possibility of skin grafting. She began to realize that her "unsightly mess" as she termed her burn wound would leave a permanent scar. At this time, she was undergoing compress treatment in preparation for skin grafting.

It was interesting to note that *Dan* did not exhibit any characteristics of this phase. He consistently seemed to be in control of himself and his recovery experience. *Dan* seemed very accepting of his burn injury which included facial burns and his emotions did not fluctuate widely.

During this period, when latent reactions to the burn injury emerged, some patients began to experience nightmares and vivid dreams about their accident. The patients stated that it was a great help to be able to talk about the nightmares to the nurses. The nurses were able to reorientate them to their present surroundings when they awakened in the night.

Phase three

Several times during their recovery, the patients set goals and realized their personal limits in relation to the demands of burn treatment.

This reality testing was usually relative to pain as pain was the predominant force in these burn patients' lives with the appearance of the burn wound as a possible secondary force. However, concern about the future appearance of the scar tissue was more apparent upon discharge, during the last phase.

The greatest potentiators of pain and ensuing anxiety were the various burn treatments, especially the dressing changes and debridement during bathing. The nature and severity of the pain varied considerably with each individual. The pain experienced during treatments was the most constant factor affecting these people, both physically and emotionally. Controlling their reactions to the pain and keeping their emotions within manageable limits was a goal set by all the patients during this phase.

Dan was able to describe his pain experience in vivid detail. He could not compare the pain of debridement during his burn bath and the pain of compress treatment to any he had suffered before. At times, he would think that his pain threshold had been reached but he was always able to "put up with it a little longer." Dan described three types of pain he had experienced:

- a deep throbbing pain which felt searing and burning on the surface
- the tingling "pins and needles" pain when his burns were exposed to air
- the "nice, acceptable" dull, general ache after the skin grafts had been applied.

Dan's pain seemed most severe during the early part of his admission when he was still unable to see because of his swollen eyelids. Understandably, his anxiety was at a peak at this time because he feared what was going to happen to him. When he was able to see again, he was amazed at his appearance. He had had facial burns and looked better than he thought he would. His pain became less severe and took on a "dull" quality.

For this patient, the worst part of each day was waiting for the treatments and anticipating the pain. Each morning he was depressed wondering how severe the pain would be that day. His day was centered on the pain he experienced in the burn bath. If the pain was not too bad and was bearable, his spirits would lift and he would be in a good mood. He breathed a sigh of relief knowing that the worst pain of the day was over.

Bruce, who had burns to his calves, vividly described how much he feared the painful compress treatments. He dreaded the treatment for an hour before it took place. His mouth became very dry as he hyperventilated. After the treatment, he was in constant pain for two hours and was unable to concentrate on anything. Even talking to his wife was too much for him. However, when the nurses talked to Bruce during treatments emphasizing especially the progress he was making, he seemed better able to tolerate the procedure. He felt that he had some control over his pain and had a goal to strive towards.

Phil spoke often of his pain experience. He vividly described how dominant a force it was, both physically and emotionally. Rather than fearing the treatment itself, as Bruce and Dan did, Phil expressed a fear of pain. He wrote in his diary:

I am not afraid of my treatments, I know what they are; I am used to them and I know they will help me. But, I get a rush of fear—a fear of pain, that is.

As the pain subsided or became more tolerable for him, Phil's disposition changed positively.

It is interesting to note that neither Carl nor Sarah described their pain experience in any detail. They did not deny that pain was present, but they preferred not to review their pain experience.

Perhaps these patients' reactions to their pain experience could be related to the terminology they used to describe their surgery. Bruce repeatedly referred to himself as a wounded animal being "skinned," "carved up" or "scalped" (cut with the scalpel). Dan referred to himself as being "cut down to the meat." These two patients were very descriptive of their pain during treatments and consistently analyzed their pain experience during our discussions.

The effects of various treatments on personality were similar in all of the patients. Their emotional status and mood seemed very dependent on how painful the treatments were.

Phase four

This phase provided time for the patients to adjust to the ongoing stresses of their recovery. After passing through the acute stages of their injury and undergoing various treatments including the application of skin grafts, the patients entered this phase of recovery. One patient termed it, "the waiting period." Time seemed to pass slowly for all of them and they became philosophical and introspective.

Phil for example often wondered how this experience would change his outlook on life. He apologized for his antagonistic attitude toward the nurses and stated that this behavior must have been a "phase" he was going through. Thinking of his future outside of the hospital, he dreaded the possibility of another accident and of having to go through this experience again.

Dan on the other hand, began to realize how lucky he was to be alive. Nothing could be a great problem compared to what he had gone through. He stated, "nothing is anything anymore after one realizes that he is alive after being thought dead. Life can be snuffed out so easily. Life cannot be replaced."

Sarah began to realize the magnitude of human suffering when people are burned. She also philosophized about the burn accident.

Bruce referred to this experience as his "burn space" in relation to his total life. Every part of "life has a space and this burn space" has "boundaries" and is "finite." He reflected back over the course of his recovery and, in great detail, analyzed the pain he had suffered.

Phase five

In this last phase, near the time of discharge from hospital, patients' concerns centered on the appearance of the scar tissue and the elastic garment they were required to wear for one year. (A Jobst* mask/glove/stocking decreases the formation of scar tissue).

At the time of discharge, all patients were concerned about the alteration in their body image and the social acceptability of the scars. Some patients were anxious about leaving the security of the burn unit. Routines had become predictable. In hospital, these patients were secure with the staff who showed no qualms or "disgust" at their "unsightly mess." Now, these people were about to leave the security of the hospital and enter an environment of friends, family and strangers. The question predominant in their thoughts was, "Will people turn away when they see the garment and burn scars?"

Study summary

An important finding in this study was that the intensity of the patient's anxiety changed in response to the burn injury and treatment. There appeared to be a threshold of anxiety, unique to each patient, beyond which defense mechanisms were called into play. Furthermore, the patients passed through similar phases during the recovery period. Trends among all these people were seen throughout the course of their hospitalization.

There were many anxiety-producing stressors during hospitalization as perceived by the patients. Generally, the stressors were associated with burn treatment and patient-nurse relationships. Since these patients' lives at this time revolved around their burn injury and the people caring for that injury, these stressors were to be expected. The attitudes, actions and statements of staff members had a great bearing on the rapidity with which a trusting relationship developed and the extent to which this relationship progressed.

*Q-tips and Jobst are registered trademarks.

It is clear then that nursing actions can have a great effect upon how a patient will cope with the pain and stress of treatments. It is vitally important for nurses and others working with burn patients to have a sound knowledge of the psychological defense mechanisms and behavioral responses a burn patient may exhibit while trying to adjust and cope with his anxiety. This knowledge provides the basis for the psychological support, explanation and reassurance that is so necessary to the total care of this individual.

A helping relationship is based on emotional support, encouragement and on an atmosphere in which the patient can think through his concerns and reactions. There are many changes and adjustments for the burn patient to face. The nurse can help by encouraging him to explore his feelings and ventilate his frustrations, by assisting him to reach his highest level of functioning and by helping him to maintain a level of emotional equilibrium over his period of hospitalization.

Sharing information about the phases of treatment and respecting the individual's ability to understand and assist in his own care will go a long way in building a trusting nurse-patient relationship. For example, the patients in this study had some very practical suggestions to offer. *Dan* suggested that since the debridement of his wounds in the burn bath was the worst part of the treatment, some method of diversion be employed. A person who could talk with him during the bath would be very helpful in drawing his attention away from the painful treatment. All the patients wished more time was allowed for them to soak and relax in the tub.

Phil felt that his body adjusted to the bearable pain but that the intensity of the pain seemed to depend on which nurse changed his dressing. In *Phil's* opinion, the nurse's ability to realize when his pain threshold had been reached was very important.

Carl reinforced this opinion. He clearly indicated the nurses in whom he had confidence. They were able to minimize his pain with skill and sensitivity and recognized when his pain threshold had been reached. They would then stop the debridement of the wound.

Carl felt that nurses who talked to him during dressing changes worked *with* him. Their acceptance of his judgment about which dressing change was least painful to him allowed him some control over his pain and treatment. If a nurse was able to be flexible in this way, he did not anticipate his treatment with the same fear.

A person who has been burned confronts multiple stresses and will suffer unavoidable pain. Obviously, he needs a great deal of psychological support, explanation and reassurance from all those who care for him. If his emotional and psychological needs can be attended to early and become an integral part of nursing care, he will be better able to adjust to the burn injury and its consequences.

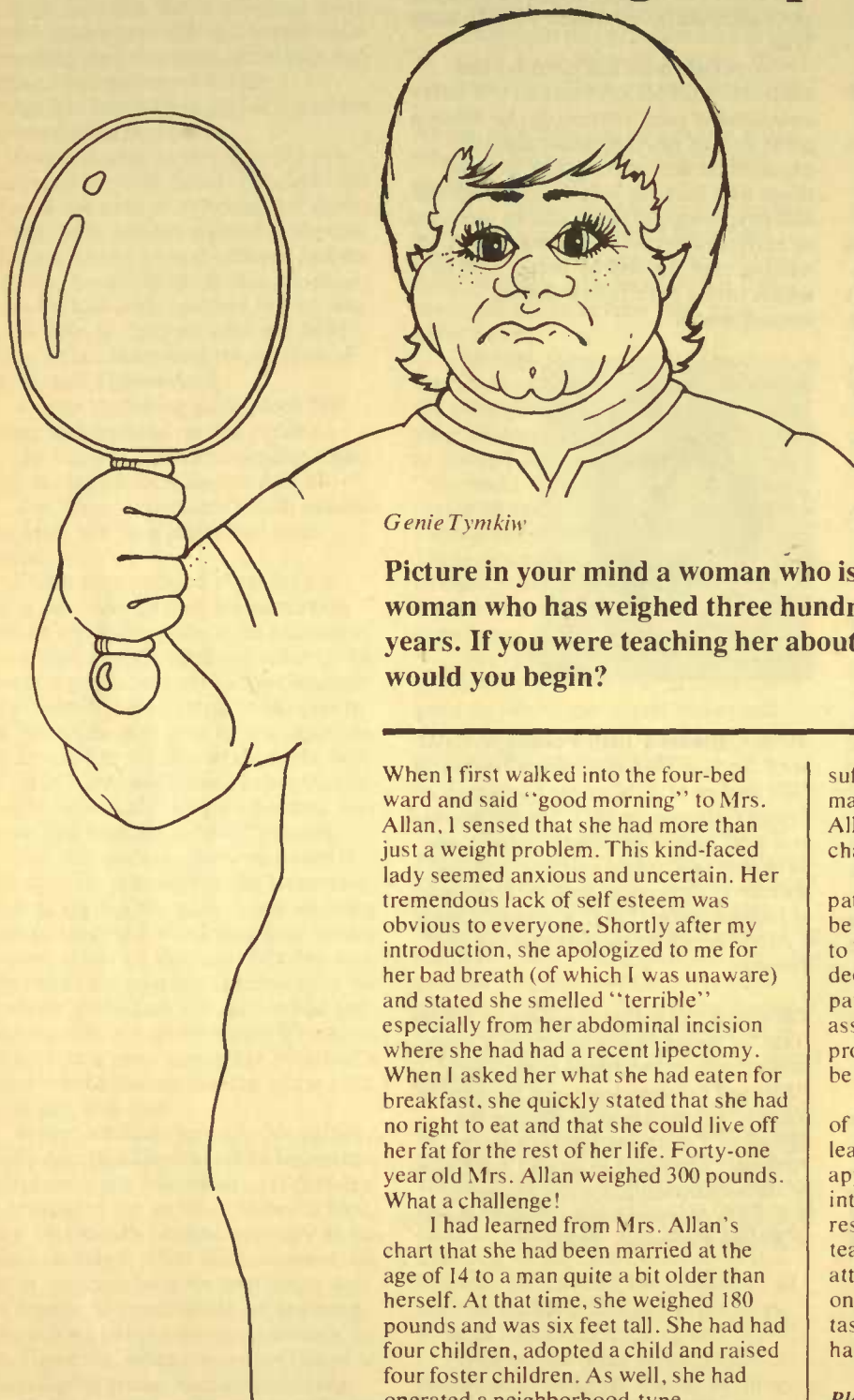


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The article "One Day at a Time on a Burn Unit" is based on one aspect of a study carried out and reported in the thesis, "Planned Informational and Supportive Nursing Interventions to Reduce the Effects of Treatment Stress in Burn Patients" presented in partial fulfillment of the requirements for the Master of Science in Nursing Degree at the University of British Columbia, 1977.

OBESITY:

A challenge for patient teaching



Genie Tymkiw

Picture in your mind a woman who is three hundred pounds, a woman who has weighed three hundred pounds for fifteen years. If you were teaching her about weight control, where would you begin?

When I first walked into the four-bed ward and said "good morning" to Mrs. Allan, I sensed that she had more than just a weight problem. This kind-faced lady seemed anxious and uncertain. Her tremendous lack of self esteem was obvious to everyone. Shortly after my introduction, she apologized to me for her bad breath (of which I was unaware) and stated she smelled "terrible" especially from her abdominal incision where she had had a recent lipectomy. When I asked her what she had eaten for breakfast, she quickly stated that she had no right to eat and that she could live off her fat for the rest of her life. Forty-one year old Mrs. Allan weighed 300 pounds. What a challenge!

I had learned from Mrs. Allan's chart that she had been married at the age of 14 to a man quite a bit older than herself. At that time, she weighed 180 pounds and was six feet tall. She had had four children, adopted a child and raised four foster children. As well, she had operated a neighborhood-type babysitting service for ten years. Now, with her family grown up, she had taken a job as a cook at a local lodge, but hoped to return to school to take a formal course as an "institutional cook."

Most of Mrs. Allan's health problems stemmed directly from her obesity. She had developed hypertension for which she took medication and

suffered from back problems due to a marked lordosis of the spine. If Mrs. Allan was to lead a healthier life, some changes needed to be made.

I knew that the task of teaching this patient about weight control would not be easy. In fact, it might very well prove to be completely futile. Nevertheless, I decided to choose Mrs. Allan as my patient for a second year nursing assignment on health teaching and health promotion. The teaching sessions would be conducted at the patient's home.

Patient teaching involves a number of basic steps: identifying patient learning needs, developing a plan of approach, implementing nursing interventions and then evaluating the results. I decided early on that my teaching would focus on Mrs. Allan's attitude towards her obesity, rather than on her other health problems. Now, my task was to learn more about her food habits and to develop a plan.

Plan of approach

My health teaching sessions were conducted during home visits to Mrs. Allan's after she was discharged from hospital. The purpose of my first visit was to establish some rapport with her and to collect information pertaining to the influences affecting her food habits and patterns. I assured Mrs. Allan that anything we discussed would be kept

confidential since this was of great concern to her. Also, because she was convalescing from her surgery, I kept the sessions short to avoid overtiring her.

Food habits, like other forms of human behavior, are the result of many personal, cultural, social and psychological influences. As such, food has many meanings and is intimately connected with a person's whole way of life. The topic of food and food habits is often a sensitive area for many people and Mrs. Allan was no exception. For this reason, I had to exercise considerable judgment and tact in planning my nursing intervention.

Our initial discussion centered on the many factors influencing obesity. Together we assessed what part these factors played in Mrs. Allan's food habits. Throughout our discussion, however, I had to emphasize the importance of one very basic fact — that other than the very few cases of physiologic disorders, obesity is always due to a consumption of more food than the individual requires.

Age and sex

Though obesity may occur at any age and in either sex, it is most common in women after puberty and is especially liable to occur after pregnancy and at the menopause.

Mrs. Allan had her first child at the age of 16. With each successive pregnancy, she gained weight and failed to lose all of the weight following delivery. She gained 80 pounds with her third child and for the past fifteen years had maintained her present weight of 300 pounds.

Physical activity

Obesity is seldom found in those who lead active lives or are involved in occupations or recreational pursuits requiring hard physical exercise. Numerous investigators report that obese subjects generally consume fewer calories than nonobese ones, but their activity level is usually lower.

Inactivity has certainly been a factor influencing Mrs. Allan's obesity. She felt, however, that as a housewife she had worked very hard at maintaining a home and rearing children during her life. We talked about this and I pointed out that although housewives do work hard, many of them do not realize the benefits of their efforts from a physical health standpoint. Also, Mrs. Allan did not participate in any regular physical activity or exercise.

Heredity

Obesity, especially excessive obesity, tends to be familial; obese children often have obese parents. However, studies have shown that it is probable that the familial influence is a situational one that molds food habits so that excessive food preparation and food consumption becomes a normal, family habit.

Mrs. Allan definitely had a familial history of obesity. She is of Russian descent and stated that she had an uncle who was well over six feet tall and weighed 350 pounds. Both her father and mother were large, obese people. Two of Mrs. Allan's daughters were grossly overweight although Mrs. Allan did not remember them being particularly large babies. One of the daughters is married but states she will not have children because she does not wish to pass on the "genes" of obesity to her children.

Psychological factors

Some people overeat for emotional or psychological reasons. Eating may well be an individual's protective mechanism from deeper emotional problems.

In discussing this point with Mrs. Allan, she stated that she had eaten out of frustration on many occasions especially throughout her pregnancies. She had been unhappily married for the last ten years and had experienced an "identity crisis" within the last five years as she attempted to escape the depressions of "housewife syndrome" and make a new life for herself.

Cultural influences

Food habits are among the oldest and most entrenched aspects of many cultures and can exert deep influence on behavior. To a large degree, the cultural background determines what shall be eaten, as well as when and how it shall be eaten.

Mrs. Allan felt that her ethnic background had definitely influenced her dietary habits. The food habits related to Russian and Eastern European customs include eating grains and potatoes in bulk, especially in the lower income groups. Pork and pork products such as sausages, as well as sauerkraut, cottage cheese and yoghurt were often included in the diet along with the attitude of "eat lots."

Plan of intervention

At this point, I had to decide what interventions might be successful in helping Mrs. Allan deal effectively with

her weight problem. Our discussion of the factors contributing to obesity had provided me with some insight into how she felt about her weight. Her attitude was most definitely one of resignation:

"I will always be fat, it runs in the family"

"I love to eat and want to make cooking my career"

"I always start on a diet every Monday but the only time I ever really lost weight (50 lbs) was before I had my hysterectomy and then I put it all back on again"

"I like my family doctor because he doesn't lecture me or blame me for not trying"

"I think you will be just another one of those people with a new diet plan up your sleeve and always ready to give me another lecture."

It seemed that emphasizing the old standbys of dieting and exercise alone would be of little value to Mrs. Allan. Thus, I decided not to direct my plan of intervention only on these activities. Instead, I tried to have Mrs. Allan think of her health in relation to her personal goals.

"Focus on the future" was the theme of my intervention. At 41, Mrs. Allan was still a young woman and on the threshold of a new lifestyle. She looked forward to greater independence now that she had established herself in a job as an institutional cook. She wanted to make her own 'mark' in life stating that she had twenty-five good working years ahead of her and wanted to make the best of them.

Obesity predisposes a person to early occurrence of other health problems and significantly shortens the life of an individual. My specific plan was to emphasize the increased stress that obesity will exert on Mrs. Allan's health as she grows older.

On my next visit, Mrs. Allan and I reviewed the changes that occur during the normal aging process. Then, I explained how the added problem of obesity would severely aggravate these changes. For example, with advancing age, bones become more porous and mineralization decreases. Mrs. Allan had already experienced back problems because of her added weight. I explained that her excess weight would, in time, compound the complications of osteoporosis. In turn, decreased function of bone often leads to a decrease in activity level, hence the tendency to gain more weight with advancing age. It is

easy to see why it becomes a vicious cycle.

Another example we discussed was the effect obesity had on cardiovascular function. With increasing age, normal physiological changes occur in heart cells which cause the heart to work harder. Heart valves lose their elasticity and blood vessels become thickened and rigid. With Mrs. Allan's history of hypertension, her heart was already working overtime. Besides this, the sheer effort involved in moving her overweight body around contributed to an overworked heart.

Obese individuals have abnormally high serum lipid levels which predispose them to the development of atherosclerosis. The formation of lipid plaques on the lumen of arteries, arteries that are already undergoing age changes, certainly presents a dismal picture in relation to circulation and proper heart function.

Mrs. Allan was particularly concerned about the possibility of developing diabetes, especially since there was a history of diabetes in her family. I explained that there was definitely a correlation between the disease and obesity particularly in a genetically predisposed individual.

Evaluation

Mrs. Allan is an intelligent woman. There was not very much that I could tell her that she did not already know. Over the past years, she had been involved in weight control programs and had received counseling from dieticians numerous times and encouragement from her physician. She had never had any particular pressure from her husband to lose weight and the general family attitude towards obesity was one of acceptance.

The opportunity to do patient teaching in a home setting was a positive experience. The problem of obesity covers a very broad range and needless to say, the nurse's responsibility in assisting the patient to change food habits and practices is difficult. Very often, knowledge about proper nutrition and adequate exercise is not enough to effect a change in an individual even though they may be well aware of the detrimental effects of obesity. Indeed it sometimes takes a life-threatening incident such as a heart attack or serious illness before an individual is really motivated to improve his level of health.

Mrs. Allan had lived with obesity for many years and it was unrealistic to expect dramatic changes in her lifestyle.

Therefore, I challenged Mrs. Allan to set some realistic goals for weight loss. For example, after recovering from surgery, Mrs. Allan hoped to enroll in a program to become a certified "institutional cook." She admitted to me that one of her worst habits in the kitchen was "tasting and testing" everything, not just a little but a lot. Keeping this in mind, Mrs. Allan agreed to work at weight reduction by:

- promising herself that she will not eat anything unless she is sitting down at the table in a proper "eating situation."
- that since she will be within walking distance of the school where she is taking her course she will walk as often as possible.

In evaluating the home visits, I feel Mrs. Allan benefited from the teaching sessions. She particularly enjoyed discussing her health problems with someone who cared. However, her concluding remark seemed to sum it up. "Don't expect me to look like Farrah Fawcett the next time you see me."

Follow-up

In doing a follow-up contact with Mrs. Allan some months later, I was not very surprised to hear that she still weighed 300 pounds. Though she had not made a "concerted" effort to limit her food consumption, she managed to walk to school frequently and stated that she enjoyed the opportunity for fresh air and exercise. This, at least, was a positive step towards a better lifestyle.

Mrs. Allan was especially pleased with the results of her lipectomy surgery for she was no longer troubled by the chafing that had caused her so much discomfort. She was extremely excited about the program she was involved in and I was pleased to share in some of her pride and satisfaction in her new career. All of these were signs that her self esteem was growing.

At this point I felt that Mrs. Allan's resigned attitude towards her weight problem had not yet changed. I could only conclude that further teaching sessions with her might have led me to a better understanding of her attitudes and behavior patterns. Certainly, more time with her would have helped me to more effectively assess and plan nursing interventions.

Bibliography

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- 2 Davidson, S. *The principles and practice of medicine* 8th. ed. Edinburgh, Livingstone, 1966.
- 3 Williams, Susan R., *Nutrition and diet therapy*, 3d. ed., Saint Louis, Mosby, 1977.



Author, Genie Tymkiw, wrote "Obesity: a challenge for patient teaching" while in her second year in the diploma nursing program at Okanagan College in Kelowna, B.C. Married with four children, Genie says "I have found the nursing course a real challenge. I've been thrilled with the experiences I've had and can't wait to graduate in December." She is also the president of this, the first graduating class of diploma nursing students from the college.

Calendar

November

Order of Nurses of Québec Annual General Meeting to be held on November 8-10, 1978 at the Queen Elizabeth Hotel, Montreal. Contact: *The Order of Nurses of Québec, 4200 Dorchester St. West, Montreal, Québec, H3Z 1V4.*

(W) Holistic Health 1978. The Association for Humanistic Psychology's Holistic Health Conference to be held on November 17 and 18, 1978 in the University of Toronto Medical Sciences Building. Oriented towards people in the healing arts. Fee: A.H.P. members: \$50. Non-members: \$55. Contact: *Toronto Association for Humanistic Psychology, P.O. Box 263, Station Z, Toronto, Ontario, M5N 2Z4.*

December

National Conference on Nursing Research, to be held on Dec. 13-15, 1978 at the Fort Garry Hotel in Winnipeg, Manitoba. Theme: Methodology in nursing care research: issues, innovations and problems. Contact: *Dr. Helen Glass, School of Nursing, University of Manitoba, Winnipeg, Man. R3T 2N2.*

January, 1979

Nursing Care of the Sick Newborn. A five-day course to be held at the Hospital for Sick Children in Toronto on January 29-February 2; April 16-20; June 4-8, 1979. Fee: \$95. Contact: *Hilda Rolstin, Coordinator, Nursing Education, The Hospital for Sick Children, 555 University Ave., Toronto, Ontario, M5G 1X8.*

Overview of Pediatric Rehabilitation Course—A Multi-disciplinary Approach to Management. To be held on January 22-26, 1979. Fee: \$100. Contact: *Ann M. Campbell, R.N., The Education Department, Ontario Crippled Children's Centre, 350 Rumsey Road, Toronto, Ontario, M4G 1R8.*

February

Helping the dying child and his family. A one-day conference to be held on Feb. 21 and Feb. 28, 1979 at the Hospital for Sick Children in Toronto. Fee: \$25. Contact: *Hilda Rolstin, Coordinator, Nursing Education, The Hospital for Sick Children, 555 University Ave., Toronto, Ontario, M5G 1X8.*

Advanced Adult Patho-Physiology. A series of ten lectures to be presented by the University of Ottawa. To be held in Ottawa from Feb. 6-April 10, 1979. Contact: *Alberta Casey, Coordinator Continuing Education, University of Ottawa, School of Nursing, 770 King Edward Ave., Ottawa, Ont., K1N 6N5.*

March

Second National Meeting of the Nurses Association of the American College of Obstetricians and Gynecologists to be held March 7-9, 1979 in Chicago. Contact: *NAACOG, Suite 2700, 1 East Wacker Drive, Chicago, Illinois, 60601.*

First International Nursing Seminar, "Quo Vadis Nursing", presented by the Dept. of Nursing, Long Island Jewish-Hillside Medical Centre, New York. To be held on March 12-22, 1979 in Israel. Contact: *Ann J. Boehme, Continuing Education Coordinator,*

Office of the Dean of the Clinical Campus, Long Island Jewish-Hillside Medical Centre, New Hyde Park, New York 11040.

April

Operating Room Nurses of Greater Toronto Eleventh Conference. To be held on April 30-May 2, 1979 at the Skyline Hotel, Toronto. Operating room and recovery room nurses welcome. Contact: *Doris Calvery, Convener, Publicity Committee, 644 Sheppard Ave., East, Apt. 325, Willowdale, Ontario, M2K 1C1.*

May

Pediatric Nursing Conference. A three-day conference to be held May 16-18, 1979 at the Hospital for Sick Children in Toronto. Fee: \$60. Contact: *Hilda Rolstin, Coordinator, Nursing Education, The Hospital for Sick Children, 555 University Ave., Toronto, Ontario, M5G 1X8.*

Fourth Annual Congress of the Oncology Nursing Society to be held at the Fairmont Hotel, New Orleans, La. on May 17-19, 1979. Contact: *Oncology Nursing Society, P.O. Box 33, Oakmont, Pa. 15139.*

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Names and Faces

Jessie Elizabeth Lawson, OSJ, CD, QHNS has been appointed Chief Nursing Officer (Volunteer) for the St. John Ambulance Brigade, a position that has been vacant for several years.



Colonel Lawson is a native of Campbellton, N.B. where she graduated from the Soldier's Memorial School of Nursing. In 1951 she joined the Royal Canadian Air Force. Shortly after, she attended the United States Flight Nurses Course and was stationed in Hawaii where she flew aeromedical evacuations during the Korean airlift. In 1956 while serving in Italy, she set up nursing services for the Canadian Forces during the Suez Crisis and later was posted as director of nursing for the Canadian Forces Hospital in Baden-Soellingen, German.

Since returning to Canada in 1963, Lawson has held many nursing administrative positions. Currently she is director of nursing services for the Canadian Forces Medical Services.

Anna Louise Freeman is the first recipient of the \$3,000 Frances MacDonald Moss Scholarship awarded by the Registered Nurses Association of Nova Scotia. A former president of the Nova Scotia branch of the Canadian Council of Cardiovascular Nurses, Freeman is pursuing a clinical nurse specialist degree

in pulmonary nursing concurrent with a Master's degree in medical-surgical nursing at the University of Arizona. She is on leave of absence from her position as head nurse and educational coordinator of the Intensive Care Respiratory Unit at the Victoria General Hospital in Halifax.

The Alberta Association of Registered Nurses has awarded three educational scholarships to nurses as part of their \$38,500 allocation for continuing education:

Marion Elizabeth

Gourlay, a nurse consultant in private practice in Calgary, is the recipient of the Abe Miller Memorial Scholarship. She will begin study in the Master's of Health Science Program at McMaster University in Hamilton.

The Helen M. Sabin scholarship was awarded to **Janet Earle Smith**, previously on the Faculty of Nursing at the University of Alberta and now enrolled in the second year of a Master's in Education Program at U of A.

Jeanette Adeline Boman, previously of the Faculty of Nursing at Grant McEwan Community College in Edmonton, has received the AARN Provincial Council Scholarship. She is enrolled in the second year of a Master's in community development program at the University of Alberta.

Marguerite Hornby Muise (B.Sc.N., Mt. St. Vincent; M.S., Boston) has been appointed registrar for the Registered Nurses Association of Nova Scotia. She succeeds Frances Moss who recently retired from the position.

Pauline Rivard has recently assumed the position of registrar with the New Brunswick Association of Registered Nurses. A graduate of the University of Moncton and Ecole Conway in Edmundston, N.B., Rivard has worked as a general duty nurse and as an instructor at the University of Moncton School of Nursing.

Margaret (Peggy) Rosso has been appointed as nursing consultant with the Saskatchewan Registered Nurses Association. She holds a B.N. from McGill University and a Master of Science in Nursing from the University of Western Ontario. Most recently she was the education and research coordinator at the Plains Health Centre, Regina.



Gabrielle Pahl (R.N., St. Mary's School of Nursing, Sault Ste. Marie) has begun a two-year tour of duty in Nicaragua with Medico, a service of Care. She will be working with a mobile health clinic visiting outlying colonies in a community health program in and near Nueva Guinea in rural Nicaragua.

Gabrielle has worked in a number of settings including the Columbia Presbyterian Medical Centre in New York, the Vancouver General Hospital and has served as a CUSO volunteer in Gombak, Malaysia from 1974 to 1976.

Jackie Roberts (R.N., Civic Hospital, Hamilton; B.Sc.N., University of Toronto; M.Ed., O.I.S.E.) has been appointed president of Niagara College in Welland, Ontario, the first woman to achieve this position in an Ontario community college. Roberts was the youngest director of nursing in Ontario in 1962 at the Public General Hospital in Chatham, and served as the director of the Osler School of Nursing in Toronto. Most recently she was vice-president (academic) at Humber College in Toronto.

Peggy Saunders, (R.N., B.N., M.Sc.(A)N.) has been appointed to the position of Community Health Nursing Consultant in the province of Alberta. She will be responsible for community health programs with particular emphasis on maternal and infant care; consultative services to designated health units throughout the province; educational/information services; research; and the community health component of all services.

Mereldine Schramm (R.N., St. Michael's General Hospital, Lethbridge, Alta.; B.N., McGill University, Montreal) has recently been appointed director of nursing at St. Paul's Hospital (Grey Nuns') of Saskatoon. She has had previous experience as staff nurse, teacher of nursing, patient care coordinator and director of patient services. Schramm comes to St. Paul's from The Pas, Manitoba, where she has been director of patient services at The Pas Health Centre for the last two years.

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(M. Murray Nierman, "Cutis", Oct. 1976)

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(Helga Vetra, Derrick Whittaker, Geriatrics, Aug. 1975)

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Research

Resumes are based on studies placed by the authors in the CNA Library Repository Collection of Nursing Studies.

Exploratory Study of the Quality of Pain Experiences in Selected Hospitalized Patients. Nursing research by *Peggy Overton, B.Sc.N., M.H.S.A., Shirley Stinson, R.N., Ed. D., Rene Day R.N., M.S.* of the Faculty of Nursing, University of Alberta, Edmonton, Alta., 1977.

This research investigated the qualities of pain experienced by selected patients in hospitals and explored the relationships between qualities of pain and level of anxiety, depression, mental awareness and independence in activities of daily living. One hundred and forty-nine adult patients from two hospitals were included. Data collection was by patient interview. A variety of multivariate techniques was used in the analysis. Factor analysis was applied to identify the major constructs being measured. A six-factor oblique solution was obtained which included one pain factor, three anxiety and depression factors, one mental awareness factor and one level of independence factor. Factor scores were obtained and analysis of variance was used to examine differences between various groups of patients.

There were no significant differences between patients of different age, sex, diagnosis, and duration of pain in relation to their qualities of pain. Level of independence in daily activities was the best factor for discriminating between patients. A number of problems were experienced in this research in assessing the reliability and validity of the measures of pain, anxiety and depression and further research is suggested in this regard.

Family Members' or Friends' Attitudes toward their Participation in Nursing Care of Hospitalized Cerebral Vascular Accident Patients. Toronto, Ont., 1977. Thesis (M.Sc.N.), University of Toronto by *Kathleen M. Welnetz.*

The purposes of the study were to describe the reactions of family members or friends toward helping with the nursing care of hospitalized cerebral vascular accident patients and to examine the potential influence of selected characteristics of patients and significant others on general attitudes toward participation in care.

The sample consisted of 30 significant others who visited CVA patients in the hospital. A structured interview schedule was administered to each subject approximately one week after the patient's admission to hospital or one week after the diagnosis of stroke. General attitudes toward participation in care were summarized from subjects' responses to an attitude questionnaire. Responses were analyzed according to: (1) extent of participation on psychological and physical care and (2) factors influencing attitudes.

Twice as many subjects reported favorable rather than unfavorable attitudes toward participation in care, although one-fifth of the sample held neutral positions. Subjects generally favored participation in the patient's psychological care, but were hesitant about participating in physical care.

Subjects' responses were favorable toward the cooperation of nurses and capabilities of significant others. Although subjects considered family participation in care to be

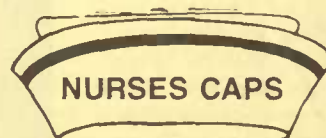
good for the patient, they were uncertain if this care would improve the nurse-patient relationship. Responses were equally favorable and unfavorable toward the extension of visiting hours.

When patients had weaknesses or difficulties prior to hospitalization, the incidence of favorable attitudes in significant others toward participation in care was greater than when patients were independent prior to their hospitalization. The number of subjects with favorable attitudes also became greater as the extent of patients' disabilities became more severe. More younger than older and more

middle-class than lower-class significant others favored participation in care.

The small, selected sample precluded generalizations. Findings suggest that nurses should: (1) be aware that the relationships between the cerebral vascular accident patients and their significant others need to be maintained in the hospital, (2) foster the supportive role of the significant others in the patient's care, (3) teach and assist those significant others who desire to participate in physical care, and (4) be sensitive to the unique needs of significant others who hold unfavorable attitudes toward participation in care.

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Books

A very easy death by Simone de Beauvoir, Middlesex, Penguin, 1969.

Five years before Elisabeth Kübler-Ross published *On death and dying*, outlining her perception of the crises met by terminally ill patients, Simone de Beauvoir wrote *A very easy death*. What Kübler-Ross' book described in clinical, even statistical fashion, de Beauvoir described in 1964 with searing intimacy.

A very easy death is the story of the death of de Beauvoir's mother. The most astonishing feature of the book is the self-deception practiced by a brilliant woman of scrupulous honesty. In spite of her conviction that her mother never knew of her condition, the author reiterates remarks made by her mother which demonstrate explicitly that the sick woman knew she would never see her beloved apartment again. Indeed, Françoise de Beauvoir left instructions for her funeral "in a hand as stiff and firm as when she was twenty". Simone's mother is gripped by what is now referred to as "a closed awareness", but the author suffers from it no less.

Madame de Beauvoir died in a private Parisian clinic, with the best of medical care and filial attention, and yet more than once Simone acknowledges that her mother died "alone". We are left with the question as to whether the aloneness would have been such a burden if there had been no deception.

Simone, for her part, watches, deceives, is deceived, and passes through her own stages of anger and grief. She begins with a conviction that she is prepared for her mother's death. That comfort was achieved, however, before the cancer had been diagnosed. At that time, Françoise de Beauvoir appeared to be suffering only from a broken femur. With the best of care, the best could be expected. There was no real reason to fear. It was easy at this stage to say "she was of an age to die".

But when a doctor finally admits to Simone that her mother has cancer, her immediate reaction is one of disbelief. She dismisses her denial in retrospect with the assertion that children are always the last to admit that their mother has cancer. "We believed it all the less since that was what she had been afraid of all her life."

There follows a classic conflict between the duty of medical practitioners, determined to follow their calling to the uttermost, and the anger of Simone and her sister, Poupette, at the "torturing" of a woman who is going to die in any event. And yet Simone is unable to resist the surgeon's proposal to operate in spite of a nurse's warning against surgery. Her agreement to the operation can be seen as a form of "bargaining". Simone needs more time to make her peace with the fact that she and her mother have not been on good terms. Maman's preference for Poupette and her jealousy about the friendship between the two sisters still festers. Simone deals with her psychological wound by reviewing her mother's life from her mother's point of view, and by supreme attentiveness to the dying woman.



Eventually, watching the continued sacrifice of the quality of life to the quantity of life, Simone falls into despair. She blames herself for the deception being practised on her mother, for her mother's suffering and loneliness, and she attempts to dissociate herself from it. "Despairingly, I suffered a transgression that was mine without my being responsible for it and one that I could never expiate."

In the book, de Beauvoir never accepts the manner or even the fact of her mother's death. She makes progress towards a reconciliation, however. The extra thirty days "won" by the operation "saved us, or almost saved us, from remorse." The funeral ritual helps to mitigate the remaining remorse by bringing the reflection that "We were taking part in a dress rehearsal for our own burial." Yet at the end, Simone is still voicing her anger, and displacing it from one specific death to the general

nature of mortality. "All men must die: but for every man his death is an accident and ... an unjustifiable violation."

If we were to take Simone de Beauvoir's diary of a death at face value, we might simply accept that her mother, Françoise, never really experienced dying. Simone assures us that she never knew that she had cancer and always believed that she would be well again. She supports her assertion by the fact that her mother, whose "whole life turned upon religion", did not ask for a priest or entertain religious friends concerned for her soul. She denied her condition and encouraged others to do the same. From time to time, however, Françoise brings up the subject of death, giving her daughter an opportunity to voice something other than well-meant lies. Even before her doctor is aware of her real condition, Madame de Beauvoir is reflecting: "Death itself does not frighten me; it is the jump I am afraid of."

While Simone, in print, passes more or less methodically through the experiences of those who are to die and those who are watching someone die, her mother's denial, anger, bargaining, and depression are continuous and interchanging. The expression of anger is unnatural to her convent-bred nature, but she can be difficult. She struggles "far, far away, in human loneliness" with patience and courage. But she insists with strange obstinacy on having her long hair cut off, "as though she wanted to bring lasting rest by making this sacrifice." As her body degenerates, her temperament suffers. Simone remarks on her mother's rancor and demanding nature.

But while Simone details with precision and anguish the physical suffering and the advance of the aged, fragile body towards death, the story is primarily the author's own. Her "anticipatory grief", vividly drawn in a few lines as she imagines the living body being a dead body, and her attempts at reconciliation with the inevitable might be termed "classic".

A very easy death would be a psychology class text book on dying and bereavement were it not written with the fervor and pain of first hand experience. Reviewed by Sheila Brogan, RN, Ottawa Civic Hospital.

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Books

Nursing Care for Parents at Risk by Ramona Thieme Mercer, 158 pages. Thorofare N.J., Charles B. Slack Inc. 1977.
Approximate price \$8.50

Mercer's purpose is to provide helpful approaches for persons privileged to work with parents during crucial times. She has accomplished this in a meaningful way. If nurses working with parents during the immediate postpartum period ever doubted the significance of their nursing role, this text will quickly dispel their fears and serve to motivate them to strive for a higher level of nursing care. Although Mercer states this is not a "how-to" book, as a knowledgeable and highly skilled practitioner, she does furnish the reader with many suggestions which provide a basis for more effective practice.

The first section identifies the scope of the problem and the basis for the conceptual framework. The tasks of parenting are discussed, as are nursing actions to assist parents in their parenting role. The author highlights well-meaning but erroneous efforts that nurses employ to protect parents from unpleasant situations.

Section two deals with special problems which place parents at risk, and describes methods that may be used to assist parents in various situations. Areas included are: the infant with a defect, the mother who experiences a threat to her life, the infant who is born prematurely, and premature (adolescent) parents. Each chapter contains an overview of the developmental tasks and details specific to the particular crisis. The author describes parents' responses and deals realistically with the nurses' feelings and responses to situations discussed. Consideration is given to the emotional, physical and social aspects in each area.

Mercer challenges nursing to examine outdated rules that do not look at the extenuating circumstances but which continue to separate mother (parents) from their infants. She states that it is time to consider the real issues on a scientific basis and to establish priorities.

This sensitive, well-documented text will be valued by any nurse who has the opportunity to work with parents of

young infants. It should be available in all maternity units, children's units and community health agencies. It would provide a useful reference for nursing students, and would be a valuable asset to the library of any maternity nurse.

*Reviewed by Shirley MacLeod,
Associate Professor, University of New
Brunswick, Fredericton, N.B.*

Elements of research in nursing 2d ed. by Eleanor Walters Treece, and James William Treece. 349 pages, Mosby, Toronto, 1977.
Approximate price: \$8.35

The stated aim of this book is "to take individuals who are interested in research to the point where they are able to conduct a research project." In addition, the authors hope that "after individuals read the book, they will be able to appreciate and critique research reports written in nursing and non-nursing disciplines."

The contents of the book are reasonable in terms of the stated aim. The book is divided into six major parts, namely: The Research Process; Theory and Method; Preparation for Collecting Data; Collecting Data; Analyzing Data; Presentation of Findings.

The teacher's use of the text will depend on her own background of preparation and experience in research, her approach to the course and teaching techniques and the printed resources available to her. One gains the feeling in reading the text that the authors are speaking at length and in detail out of such a teaching experience.

Some of the text (Part I) presents essentially others' viewpoints gleaned from the literature and as such, it could become quickly outdated. While some references from Canadian publications are cited, there is a wealth of material related to research in nursing in Canada which this book does not touch — nor does it purport to do so. In other parts of the book, there is almost a cookbook recipe approach to presentation of material. For some teachers and some students, this could be of great value. Throughout, major concepts presented are well-illustrated.

It is interesting that the authors have elected to include information regarding

descriptive statistical analysis of data and have excluded information regarding inferential statistical analysis. The authors offer their rationale for this decision regarding such content, included or excluded. Content analysis of data is not incorporated, despite the fact that several approaches to research which are discussed in Part IV would elicit data which would necessitate qualitative data analysis. A case could be made for a text in research in nursing which excludes any reference to statistics and leaves that to the texts on statistics.

There is the occasional statement made in the text which one could call into question (e.g. p. 34 — "Social scientists seem to do research for prestige and status"). There are also occasional statements made in one part of the text that are not congruent with subsequent statements.

This text would have particular value for those interested in nursing research at a beginning level who do not have access to texts on research methodology in related disciplines or a wide variety of current journals reporting research in nursing or articles about nursing research. I would recommend reading the summary at the end of each chapter before reading the chapter. These summaries are set forth succinctly and in logical order and present the major concepts of the chapter.

*—Reviewed by Amy Griffin, R.N., Ed.
D., Professor, The University of
Western Ontario, Faculty of Nursing,
London, Ontario.*

Pediatric nursing: a self-study guide 3d ed. by Norman J. Anderson. St. Louis, Mosby, 1978.
Approximate price: \$9.25

The text *Pediatric Nursing — a self study guide* is not only an excellent learning tool for pediatric nursing students, but it also offers a challenging review for graduate nurses working with children in any aspect of health care.

The book is written in case history format and presents hypothetical situations of children in states of health and illness. The questions and special projects which follow each case history presentation incorporate pathophysiology, medical management,

nursing care, growth and development and the family. This method of presentation encourages the reader to apply knowledge from the clinical setting to the workbook and assists the reader to think and work in a more organized fashion. A detailed list of references is supplied at the end of each section.

Throughout the text, the author deals with the child as a member of a developing family unit, thus aiding the reader in a better understanding of the child and the family.

An interesting and informative text — a worthwhile consideration for anyone involved in the nursing care of children.

Reviewed by Alison Collins, Memorial University of Newfoundland, School of Nursing, St. John's, Newfoundland.

Library Update

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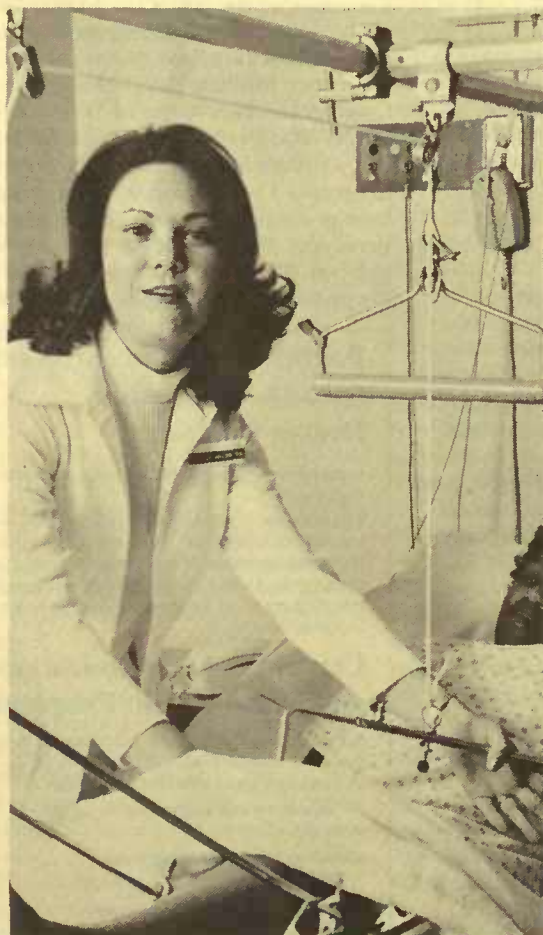
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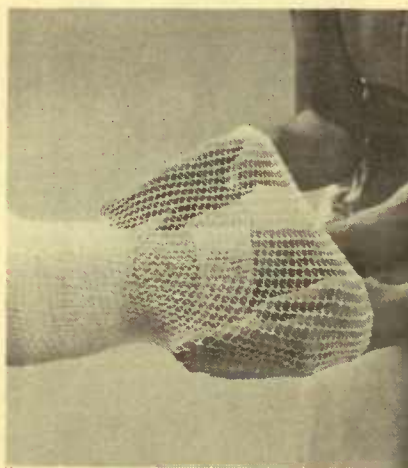
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The enzymatic activity is also adversely affected by detergents and hexachlorophene and heavy metal ions such as mercury and silver which are used in some antiseptics. When it is suspected such materials have been used, the site should be carefully cleansed by repeated washings with normal saline before Santyl Ointment is applied. Soaks containing metal ions or acidic solutions such as Burrow's solution should be avoided because of the metal ion and low pH. Cleansing materials such as hydrogen peroxide or Dakin's solution do not interfere with the activity of the enzyme.

Debrided patients should be closely monitored for systemic bacterial infections because of the theoretical possibility that debriding enzymes may increase the risk of bacteremia.

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Experienced Nurses (eligible for B.C. Registration) required for full-time positions in a new 300-bed Extended Care Hospital located just thirty minutes from downtown Vancouver. Salary and benefits according to RNABC contract. Applicants may telephone 525-0911 to arrange for an interview, or write giving full particulars to: Personnel Director, Queen's Park Hospital, 315 McBride Blvd., New Westminster, British Columbia, V3L 5E8.

Experienced Nurses (B.C. Registered) required for expansion to 463 bed acute, teaching, regional referral hospital located in Fraser Valley, 20 minutes by freeway from Vancouver, and within easy access of various recreational facilities. Excellent orientation and continuing education programmes. Salary: \$1184.00-\$1399.00 per month (1977 rates). There is an immediate need in coronary care, intensive care, operating rooms and hemodialysis because of increased services. Other clinical areas include medicine, surgery, obstetrics, pediatrics, emergency and rehabilitation. Apply to: Personnel, Royal Columbian Hospital, New Westminster, British Columbia, V3L 3W7.

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Newfoundland

Positions available immediately for **Registered Nurses** in a 40-bed fully accredited General Hospital. Experience an asset. Salary according to government scale \$11,448, presently under negotiation. Residence accommodation available. Apply to: Director of Nursing, M.J. Boylen Hospital, Baie Verte, Newfoundland, A0K 1B0.

Ontario

Renfrew County and District Health Unit — Public Health Nurse — The Renfrew County and District Health Unit has an immediate opening for a qualified Public Health Nurse. Applications, outlining full details of education and experience, are to be directed to: Mrs. Reta McBean, Director of Nursing, Renfrew County and District Health Unit, 1217 Pembroke St. East, P.O. Box 940, Pembroke, Ontario, K8A 7M5.

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Applications are invited for the position of **Registered General Duty Nurse** in a small 18-bed hospital located in the beautiful rural northwestern Saskatchewan. Salaries, fringe benefits, etc., as per S.U.N. Agreement. Apply to: Margaret Lathan, Director of Nursing, Box 179, Paradise Hill, Saskatchewan, S0M 2G0; or phone: (306) 344-2255.

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The Canadian Nurses Association does not review the personnel policies of the hospitals and agencies advertising in the Journal. For authentic information, prospective applicants should apply to the Registered Nurses' Association of the Province in which they are interested in working.

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DUTIES

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Concordia University
1455 de Maisonneuve Blvd. W.
Montreal, Quebec H3G 1M8



Associate Director of Nursing Services

Environment:

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Co-ordinator of Nursing — Nights

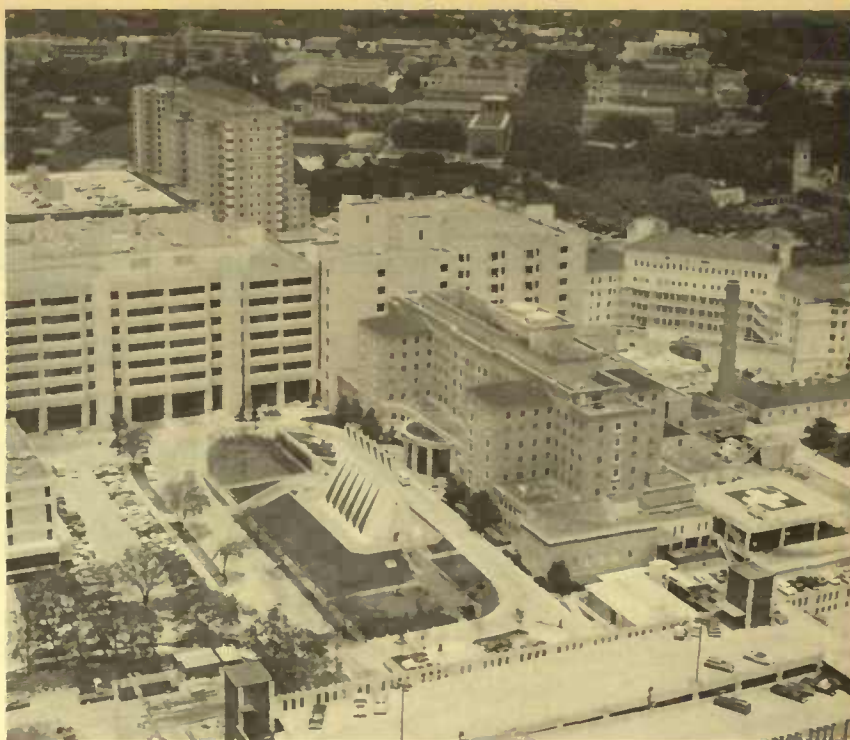
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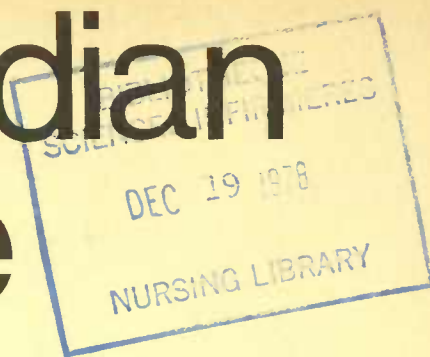
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The Canadian Nurse

DECEMBER 1978



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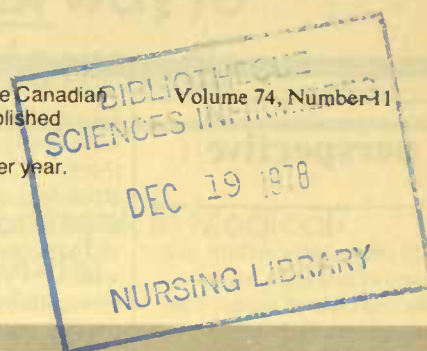
Ed. Bate

Your Clinic Shoemaker

The Canadian Nurse

December 1978

The official journal of the Canadian Nurses Association published in French and English editions eleven times per year.



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A quiet, country road in a Quebec village brings to mind thoughts of warm, cozy homes where family and friends gather together to share in the festive season. At this time of year, we wish all our readers every happiness and peace. (Cover photo courtesy of National Film Board of Canada, Phototheque.)

The Canadian Nurse welcomes suggestions for articles or unsolicited manuscripts. Authors may submit finished articles or a summary of the proposed content. Manuscripts should be typed double-spaced. Send original and carbon. All articles must be submitted for the exclusive use of *The Canadian Nurse*. A biographical statement and return address should accompany all manuscripts.

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses Association.

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perspective

All too often associations are accused of talking a lot but producing little of value. The Canadian Health Record Association has unveiled a Code of Practice for Safeguarding Health Information. It's a commendable piece of work and it can and should be a useful and valuable document for those working in the health care professions and in allied fields.

There were many favourable comments made at the CHRA annual meeting, many nods of agreement and statements of acceptance. Copies of the document both in the meeting room and adjacent areas disappeared quickly. There is a sense of fulfilment or of a mission accomplished in taking something tangible home from a meeting.

Now that these discussions have ended and the cheering has stopped, some questions remain unanswered. What will happen to this Code of Practice in the future? Will it be another addition to a collection of wall-hangings in anterooms and offices? Will it gather dust in a file? After all, there isn't anything that says, or any law that demands, that it be used.

The development of such a document by a private organization must be more than an expression of good intentions. It must be supported, it must have teeth and it must be applied.

In the final analysis, patient care is the most vital element in the confidentiality argument. It is understandable that the public we serve has lost faith in the ability we have to deal with this ethical issue.

To say that the public is not sufficiently concerned, that there is a "nothing to hide" attitude is a generalization which suggests that we are not all that concerned. Most of us who have suffered even a minor illness know that part of the success in restoring health lies in the truth. When we seek medical care we must reveal many facts about ourselves and our families; often the innermost part of us is laid bare. And the spilling of these revelations can be not just dangerous but totally destructive.

What did emerge from the CHRA discussions is the need for stiff government legislation to support the Code of Practice for Safeguarding Health Information. There were suggestions, there were a few indefinite promises, there were hopes...

Safeguarding information is our business and we have a responsibility to apply pressure where it will do the most good to ensure that the public receives the protection it requires and to enable the most effective health care. Those of us who now have a copy of the Code and who really care about the confidentiality issue can act individually, or as a group, by demanding that action be taken through legislation and enactment.

—Bert Prime, Public Relations Officer, Canadian Nurses Association.

(see also *News*, page 9, "CHRA moves to limit access to information.")

herein



January 1979 marks the beginning of the International Year of the Child. Next month, CNJ will present a series of articles on topics related to children's health — from nursing involvement on a child abuse team to programs that reduce the stress of hospitalization on young infants and children. The issue will also cover a number of current concerns about "health for kids" such as immunization and accident prevention.

Anyone interested in knowing more about what the International Year of the Child is all about is encouraged to write to: International Year of the Child, 323 Chapel St., Ottawa, Ontario, K1N 7Z2.

"Once upon a time, long ago and far away..." is, admittedly, not the usual introduction to an article on anatomy and physiology but then *The tale of the innominate war* is a most unusual nursing article. Test your knowledge of A and P and have fun at the same time. (Page 14).

Seventeen nurses in a public health unit in northern Alberta worked together to develop a philosophy, objectives and standards for their community nursing programs. They tell how you can do it too on page 24 of this issue.

How often have you nursed a child with the diagnosis "failure to thrive" and wondered what that label really means? This month, two nurse researchers, Jeannette Funke-Furber and Cheryl Roemer, share their findings about failure to thrive children, the mother-child relationship and how nurses can intervene. The article starts on page 30.

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Nursing in Society:

A Historical Perspective, 14th Edition

In the new edition of this classic text, the author has added considerable material covering the past few decades in nursing. Recent developments in nursing education and nursing practice are described, including the controversial 1985 proposal and independent nursing practice. Throughout, the progressive development of nursing to a professional status is emphasized. Many new illustrations enliven and amplify the text. A teacher's guide will also be available.

By **Josephine A. Dolan**, MA, PdD, RN, Prof. Emeritus, School of Nursing, Univ. of Conn.; Director, Center for Nursing Heritage, Storrs, CT. 402 pp., 286 ill. \$20.10. July 1978. Order #3133-9.

Barnard, Clancy & Krantz

Human Sexuality for Health Professionals

This multi-disciplinary approach to the field stresses the need for sex education and sexual counseling, and the importance of knowledge on the part of all health professionals, with emphasis on the nurse. Many nursing programs offer courses on the subject now. Contributions include material from 28 leading authorities including physicians, professional counselors, clergy, psychologists, and nurses.

By **Martha Underwood Barnard**, RN, MN, Faculty-Nurse Clinician, School of Nursing; **Barbara J. Clancy**, RN, MSN, Assoc. Prof., School of Nursing; and **Kermit E. Krantz**, MD, Prof. and Chairman, Obstetrics and Gynecology and Dean of Clinical Affairs; all of Univ. of Kansas Medical Center, Kansas City. 301 pp. Illustd. Soft cover. \$11.45. April 1978.

Order #1544-9.

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By **Rosemary Bouchard Kurtz**, RN, EdD, Assoc. Prof. in Nursing; and **Nancy Frost Miller**, RN, MS, Asst. Prof. in Nursing, both of Queensborough Community College, Bayside, NY. 191 pp. Illustd. Soft cover. \$8.60. May 1978. Order #5580-7.

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By **Karen Creason Sorensen**, RN, BS, MN, Formerly Lecturer in Nursing, Univ. of Washington; Instructor of Nursing, Highline College; Nurse Clinical Specialist, Univ. Hospital and Firland Sanatorium, Seattle, WA; and **Joan Luckmann**, RN, BS, MA, Formerly, Instructor of Nursing, Univ. of Washington, Highline College, Seattle, Oakland City College, and Providence Hospital College of Nursing, Oakland, CA. About 1185 pp., 435 ill. Ready Feb. 1979. About \$23.00. Order #8498-X.

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Input

The Canadian Nurse invites your letters. All correspondence is subject to editing and must be signed, although the author's name may be withheld on request.

Clinical articles appreciated...

I have just completed reading the September issue of The Canadian Nurse. The quality of articles seems to be increasing with each issue.

Adult aphasia and Crohn's Disease were both informative and well written.

It was Pam Haslam's article on Digitalis which prompted this note. It is one of the best articles on this important drug that I have read. I plan to incorporate it into my orientation program.
—Joan Graham, Head Nurse, Intensive Care Unit, Oakville Trafalgar Memorial Hospital, Oakville, Ontario.

Priorities

Having nursed two hungry sons through infancy, I feel obliged to comment regarding the letter on breast feeding (September). To me, breast feeding was pure pleasure for mother and babe, and the small effort being made to maintain health while so doing was well worth the trouble.

To hell with spotless houses and maintaining order in our lives. Let's have a little love!

—L.B. Halliday, R.N., Coquitlam, B.C.

P.S. Keep up the good work in an interesting magazine — The Canadian Nurse.

Native nutrition

I understand that the October issue (Vol 749) of The Canadian Nurse has extensive articles on Native health. I would appreciate receiving 2 copies of this edition of your journal for our library.

I am enclosing copies of bibliographies and a fact sheet that a nutritionist, Beverley Davis, produced for the

Canadian Association in Support of the Native Peoples over the summer. We would like this information on Native nutrition to reach as many people in the medical profession as possible, and wonder if you could help in any way.

—Jenna Hofbauer, Librarian, Canadian Association in Support of the Native Peoples.

Editor's Note: A factsheet on the nutritional status of native people and bibliographies on non-technical nutrition, comprehensive nutrition and a glossary of nutrition terms are now available from the CNA Library.

Congratulations CNJ

Bravo! I would like to add my voice to the many who, I feel certain, will be expressing their congratulations and appreciation for your October 1978 issue.

You and your staff are to be commended for recognizing the long overdue need to bring the problems of Canada's native people to the attention of nurses throughout the land. If, as you stated, the first step to improving the health status of native people is simply becoming aware of the problems as they exist, you have helped in creating this awareness by presenting an entire issue devoted to such a cause, through honest, pertinent articles.

As a novice teacher in a diploma program for registered nurses, I am especially delighted with this issue, as it enables me to direct my students' attention to a Canadian publication on Canadian nursing concerns that are relevant to their study of health and the community. To introduce first year nursing students to such concepts as

culture and its political, economical, social and ecological ramifications is, I am finding, an awesome task at times, basically because concepts can be too abstract for students to grasp the implications for nursing. Thank you for presenting concrete evidence of the necessity for all nursing programs to incorporate the cultural and community aspects of nursing.

—Ruth M. Fox, B.ScN., R.N., Teacher, Nursing Education, The Salvation Army Grace General Hospital, Winnipeg, Manitoba.

Health happenings

Results of a Canadian trial of aspirin therapy for patients with **transient ischemic attacks (TIAs)** show that this common drug reduces further occurrence of both TIAs and strokes as well as lowering the death rate.

The 12-institution Canadian study was under the direction of Dr. Henry J. Barnett of the University of Western Ontario School of Medicine.

Four 325 mg aspirin tablets per day reduced the risk of a cerebrovascular incident by 20% and reduced the risk of major stroke or death by 30% compared with a control group given placebos. The data also revealed that the effect applied only to men.

NOTICE OF ANNUAL MEETING

Canadian Nurses Association

In accordance with bylaw section 44, notice is given of an annual meeting to be held Thursday, 29 March 1979, commencing at 09:00 in Ballroom C, Skyline Hotel, Ottawa, Ontario. The purpose of the meeting is to conduct the affairs of the Association.

Individual members of the Canadian Nurses Association are eligible to attend the annual meeting. Presentation of a current provincial/territorial association membership card will be required for admission. Students of nursing are welcome as observers. Proof of enrolment in the school of nursing will be required for admission.

Helen K. Mussallem
Executive Director
Canadian Nurses Association

RESOLUTIONS FOR ANNUAL MEETING

Individual members and association members of CNA are invited to submit resolutions for presentation at the annual general meeting (29 March 1979). Resolutions must be signed by a CNA member and forwarded to CNA House by 1 February 1979. However, during the general sessions, voting delegates may submit motions pertaining to annual meeting business.

Helen K. Mussallem
Executive Director
Canadian Nurses Association

YOU AND THE LAW



The legal implications of telephone orders

Corinne Sklar

It is 11:45 pm in the hospital. Mrs. Wiley is complaining that she cannot get to sleep. Nursing measures have offered no relief. A call to her physician results in the order: Dalmane 30 mg q.hs. prn. and may repeat x1. The medication has the desired effect. Mrs. Wiley falls asleep.*

The telephone order is a simple, straightforward and often routine solution to a problem that requires some medical advice. Telephone orders occur most frequently during the evening hours, the time when most physicians are not present in the hospital.

However, even this "simple, routine practice" can have legal ramifications. It is important to be aware of these problems so that procedural standards can be developed to avoid possible injury to the patient and to protect the physician, nurse and the hospital from liability.

The physician's order sheet is the backbone of the patient's record. The orders written there outline the course of treatment the patient receives: the test, the X-rays, the medications, the therapies. Without a dated, signed written order, such treatments are not undertaken. The orders result from the physician's assessment of the patient's needs based on the history, examination, and diagnosis. The physician's determination of the necessary treatments changes, for the evaluation process is on-going, incorporating lab and other test results, vital signs, nursing observations and the results of the physician's direct examination of and discussion with the patient. The order sheet reflects this: drug choice, dosages, frequency of administration, diet, degree of locomotion permitted, these all vary with the current assessment.

Telephone orders, on the other hand, are made without the physician's contemporaneous, direct examination or evaluation

of the patient. The decision is based on the situation as it exists currently in the physician's mind and is influenced by the information given by the caller. The physician does not "see for him/herself", a fact that can lead to error and possible malpractice. This is not to suggest that telephone orders should never be taken, clearly an unrealistic solution. It is simply to point out that the telephone, while a blessing in busy hospitals, nevertheless, also constitutes a potential legal hazard to the unwary nurse.

* The major problem with telephone orders lies in the possibility of a communication gap: "the message sent is not always the message received." The misunderstanding may work both ways or it may be one-sided. In either event, the resultant distortions of the situation can have a most deleterious effect.

The nurse may err when she records the telephoned order: 25 mg may be written as 250 mg— ten times the dosage ordered. What did the doctor order? What did the nurse report? Who is telling the truth?

The resolution of such a dispute ultimately may place blame on one party, while exonerating the other. Where the patient has sued because of injury suffered, the apportioning or placing of fault will occur in the courtroom. The patient may receive compensation; the party, or parties, at fault must pay.

Nurses should be aware of the procedure, if any, required by their hospital. Rozovsky¹ outlines the typical procedure to be followed on receipt of a telephone order:

- The order should be recorded legibly with the date and time received clearly noted.

*Registered trademark.

- The order should be signed by the nurse recording it: Dr. J. Blank per Jane Doe, RN.

The nurse receiving the order should do the recording. To have another nurse record it is not good practice since this increases the chance of error.

- The order should be signed by the physician involved as soon as possible thereafter, preferably within a prescribed time period.

In the opinion of some authors, there should be strict limitations on the range of personnel who may take such orders. Creighton² suggests that only senior nurses (director of nurses, supervisors), interns and residents should be authorized to accept telephone orders. The reasoning here is that such limitation will reduce the opportunity for error. As well, more senior personnel, by virtue of their advanced education and experience, will have a better knowledge of drugs so that the danger of error will be further decreased. This kind of control clearly defines the limits of authority and further prevents delegation of this responsibility to subordinate personnel. It also facilitates ensuring that questionable orders will be clarified before action is taken so that harm to patients is prevented. Of course, such a limited system may not be practical or operative in your hospital. Again, the hospital's current procedure is important. It is imperative that nurses be aware of the proper procedural safeguards in taking telephone orders to reduce the chance of harm.

Today, nurses are taught to question orders to ensure that they are clear and correct and telephone orders are no exception. Failure to question the appropriateness of an order may result in the nurse's liability. This results because the nurse is held to the professional standard of a nurse of similar training and experience: what should the nurse have known or reasonably be expected to have known in like circumstances? What action therefore should have been taken?

Readers will remember from previous columns that a situation of emergency may serve to reduce somewhat the required standard of care. With telephone orders, however, the standard of care is not altered even if there are circumstances of emergency. In fact, it is often the emergency situation that results in harm from telephone orders. A review of some cases³ will illustrate the problems that may result. In these cases, harm occurred to the patient and the court was faced with deciding which report of the events leading to the patient's injury was the accurate version.

In *Childs v Greenville Hospital Authority*, 479 S.W.2d 399 (Texas 1972), a pregnant woman arrived at Emergency at 2 am with contractions of 30 seconds duration occurring two to three minutes apart. There was a small amount of bright red show. The patient was denied admission. The nurse claimed that in reporting the patient's condition by telephone to the physician on call, he said, "Tell the patient to get in touch with her own doctor." The physician claimed that he told the nurse "to have the girl call her doctor at Garland and see what he wanted her to do." The baby was born while the woman was en route to her doctor at Garland. The Texas Appeal Court here had to decide if the trial judge had been correct in denying judgment to Mrs. Childs. The Court found that the determination of the facts was a task for a jury to decide: was there negligence here? What was the correct version of the facts? Had the nurse properly denied the patient admission?

In coming to its decision, the Texas Appeal Court said that a nurse-patient relationship existed between the nurse and this patient. Thus, the nurse had a duty "when all the circumstances are considered, of accurately reporting to Mrs. Childs the message the doctor told her to deliver in connection with the denial of the application for admission." (p.403) It was necessary that a jury should determine whether the nurse had

reported accurately or inaccurately, and whether failure to so report accurately amounted to negligence. The Appeal Court thereupon reversed the trial judge and ordered a new trial.

In *Citizens' Hospital Association v Schoulin*, 262 So.2d 303 (Ala. 1972), the hospital was held liable where a patient came to Emergency at 4:30 am complaining of pain following a car accident. The patient said he thought his back was broken. He claimed that the nurse asked him to wiggle his toes and then she called the physician on call. The evidence was that the nurse told the physician that she could find nothing wrong with the patient and that he and his buddies had been out drinking. Thereupon, the patient was given medication for pain by the nurse and denied admission. The next day, finding blood in his urine, the patient was taken to another hospital where a broken back was diagnosed. At the trial, the doctor at the first hospital claimed that he had told the nurse to admit the patient and have X-rays and other diagnostic tests performed. The nurse claimed that he had ordered medication for pain only and had not admitted the patient.

In another case,⁴ the nurse's failure to report the patient's vital signs resulted in a judgment against a hospital and a physician. The patient was brought in to Emergency at 11:30 pm with abrasion to the frontal scalp and inability to move his right leg. The nurse called the physician on call, telling him the patient had been hit by a car and giving him the patient's vital signs. The patient was admitted and given medication for pain. The hospital was filled with influenza patients so the patient was placed in the corridor just outside the nurses' station. At 12:05 am, the patient was cool and perspiring with vital signs of B.P. 70/50, P. 120, R. 40. At 1:30 am, the patient was quieter. At 2:00 am, he was found in Cheyne Stokes respirations with no pulse. Efforts at resuscitation failed.

There was conflicting evidence heard. The physician claimed that the nurse told him that in her opinion he did not have to see the patient. The nurse denied this. The court said that the patient might have been saved had the physician personally seen the patient and had the nurse reported the patient's vital signs at 12:05 am.

These cases illustrate the conflicting reports that may derive from telephone conversations. The next case is illustrative of the importance of verifying the order. Murchison et. al⁵ gives a detailed account of this case and the Court's decision.

In *Barnes v St. Francis Hospital and School of Nursing, Inc.*, 507 P.2d 288 (Kansas 1973), a patient "of considerable girth" was given a *subcutaneous* injection of Dramamine* following his doctor's telephone order to "give the patient a hypodermic injection of Dramamine." The nurse who administered the drug charted in the nurses' notes that Dramamine was given I.M.

In this situation, the route was not specified other than by injection, i.e. hypodermically. The court found that the order was not improper, for there was abundant evidence that Dramamine if injected must be given I.M. since subcutaneous injection is irritating. (Here, the result was a fat necrosis which required further hospitalization.) It was found that the nurse should have known that the injection should only be given I.M. and further that she was negligent in its administration for not ensuring that the needle was long enough to achieve deep muscle penetration. The patient was awarded \$22,500 in damages.

This case illustrates the necessity of ascertaining the meaning of the order, especially where there is ambiguity in the use of terms. The responsibility of the nurse to know the acceptable route of administration of any drug before giving it is clear. If the route ordered seems erroneous, the nurse should verify its proper route and then check back with the physician. The nurse cannot simply say "I was following orders." She has a clear duty, even in an emergency to make sure that the order is indeed a proper one in the circumstances.

For the protection of the medical team and the hospital, the following safeguards should be considered:

1. When taking telephone orders, make sure that the physician is given all the relevant facts.
2. Repeat the order back to the physician to ensure the order has been accurately heard.
3. Clarify or question any uncertainties to assure accuracy. Chart in the nursing notes any relevant discussion.
4. Record the order promptly and legibly giving date and time and name of physician per the recording nurse.
5. Ensure that the physician signs the order on his next visit or soon thereafter.
6. If there is concern that the order may conflict with the patient's condition, it is advisable to inform the resident or intern so that further, more detailed information can be given to the ordering physician or to ensure that no untoward results occur from carrying out the order.

The nurse must know the hospital policy that prevails regarding telephone orders; but procedural conduct confirming given hospital policy is no excuse, especially where harm results to the patient. An inadequate policy is insufficient answer to harm resulting from the carrying out of a telephone order. As to professional responsibility, Creighton⁶ says it well:

"The nurse must learn the basic facts of her profession; she must learn to observe, to evaluate, and to judge a patient's condition. In addition, she must learn to perform her duties with at least the care of the ordinary, reasonable and prudent nurse in those particular circumstances. She must realize that she is personally responsible for her own wrongful or negligent acts

and that as an employee or agent she may render her employer liable.

If in doubt about a written order from a physician, the nurse should make sure that she understands it before attempting to carry it out. The situation is somewhat like the story of the bad eggs; if there is any doubt about it, there is no doubt about it. She should secure an interpretation or verification of the order if it is not clear."

Telephone orders may be necessarily expedient but nonetheless require due care and attention from all concerned.

References

- 1 Rozovsky, Lorne Elkin. *Canadian hospital law; a practical guide*. Toronto, Canadian Hospital Association, 1974. p.74.
- 2 Creighton Helen. *Law every nurse should know*. 3d ed. Toronto, Saunders, 1975. p.83.
- 3 Ibid. p.83.
- 4 *Thomas v Corso*, 288 A.2d 379 (Maryland, 1972)
- 5 Murchison, Irene A. *Legal accountability in the nursing process*. Saint Louis, C.V. Mosby Co. 1978. p.140.
- 6 Creighton, H. op cit. p.140.



"You and the law" is a regular column that appears each month in The Canadian Nurse and L'infirmière canadienne. Author Corinne L. Sklar is a nurse and recent graduate of the University of Toronto Faculty of Law and is currently articling with a Toronto law firm.

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The International Development Research Centre is a corporation established by an Act of the Canadian Parliament, May 13th, 1970. The Centre also offers Research Associate awards for mid-career professionals from developing countries.

News

CNA Directors Set Goals and Priorities

Canada's national nursing organization, the Canadian Nurses Association, has determined its priorities for the next two years and is preparing now to work towards these goals. From now until the Spring of 1980, the association's resources, manpower and money will be directed towards four top priorities:

- the definition of nursing and development of standards for nursing practice
- development of a national accreditation program for nursing education programs
- organization of a national forum on nursing education, and

- development of a Canadian Code of Nursing Ethics.

Two other areas — an enhanced program of public relations for the association and investigation of the feasibility of setting up doctoral programs in nursing in Canada — will also come under study during the 1978-80 biennium.

Determination of the CNA priorities for the next two years was one of the major accomplishments of CNA's Board of Directors during their Fall meeting October 19th and 20th. The two-day meeting was the second since the election of

officers which took place during the CNA convention in Toronto in June and the first to be held at CNA House. It was preceded by a one-day "brainstorming" and orientation session for new directors.

Directors agreed during the meeting that the definition of nursing practice and development of standards of nursing practice should be considered CNA's top priority for the biennium and that work should begin immediately on phase one of the project — the definition of nursing practice. The association will take over handling of the project in response to concern expressed by the directors that work being carried out in this area by the federal government would not meet the needs of CNA member associations. The project as it is now envisaged will be planned and carried out under CNA supervision.

In response to a resolution from membership, directors also approved plans to investigate the creation of a system of national accreditation for nursing education programs. Meetings will be convened with authorities in this area including the Canadian Association of University Schools of Nursing, the Association of Canadian Community Colleges and the National League of Nursing.

Another suggestion from membership, in the form of a resolution approved during the CNA convention, will result in the convening of a National Forum on Nursing Education some time during 1980. A five-member planning committee that includes CNA members-at-large for nursing education and nursing practice, Margaret McCrady and Jessica Ryan, will begin

work on the proposed forum immediately.

Work on the fourth priority directors agreed to, the development of a Code of Ethics for nurses in Canada, will be carried out under the direction of a project director whose name will be announced shortly. Only one province — Quebec — has already adopted its own Code of Ethics. In some other provinces, the ICN Code of Ethics is generally accepted.

Directors also approved an amendment to CNA Bylaws which will permit three "public representatives" to be appointed as directors. The bylaw amendment permitting consumer representation will be taken to CNA membership for sanction by a majority of voting delegates at the annual meeting, March 29th, 1979, at the Skyline Hotel in Ottawa. If the amendment is approved by membership, the Board of Directors will appoint public representatives from names submitted by CNA association members. The terms of office, responsibilities and privileges of these public representatives will be the same as for other CNA directors; they will not, however, be members of the executive committee.

Other decisions of the Board of Directors related to attempts to assist CNA provincial/territorial associations with activities related to health promotion and the provision of services by the association to nurses who are eligible for membership in provincial associations but are not currently members of CNA. In response to concern expressed by directors over this issue, CNA staff will prepare a proposed set of guidelines for the provision of services for the consideration of directors.

The joint committee of the Canadian Hospital Association, Canadian Medical Association and the Canadian Nurses Association has been meeting since 1946. At the October 1978 meeting the Canadian Public Health Association became a permanent member. Front row, left to right: William A. Kilpatrick, president, Canadian Hospital Association; Dr. Kenneth Wylie, president, Canadian Medical Association; Helen Taylor, president, Canadian Nurses Association; Gerald H. Daffoe, executive director, Canadian Public Health Association, and Dr. Robert Wilson, executive director, Canadian Medical Association. Second row: Fred W. Lamb, president-elect, Canadian Hospital Association; Gordon Frith, past-president, Canadian Hospital Association; Dr. Shirley Stinson, president-elect, Canadian Nurses Association; Dr. Helen K. Mussallem, executive director, Canadian Nurses Association. Back row: Dr. E.V. Rafuse, Chairman of the Board, Canadian Medical Association; James B. Flett, Treasurer, Canadian Hospital Association; Mrs. Ghislaine Haberman, Secretary to the Committee; Jean-Claude Martin, executive director, Canadian Hospital Association; Sister Mary Lucy Power, executive committee member, Canadian Hospital Association, and Douglas Geekie, director of communications, Canadian Medical Association.

Photo courtesy of Studio Impact



Health Record Association moves to limit access to information

How easy is it for someone to obtain confidential health information from a patient's chart or file where you work? According to the Royal Commission of Inquiry into the Confidentiality of Health Records in Ontario, it is probably a lot easier than you think — too easy in fact.

Since the Inquiry started in May 1978, numerous cases of people or agencies illegally obtaining confidential health information have come to light. For example, private investigation firms working for insurance companies have illegally obtained health files on at least 325 individuals. Detective agency employees have posed as doctors and nurses in order to obtain patients' medical histories from hospitals and doctors' offices. The RCMP and the Ontario Provincial Police have allegedly obtained health information from the Ontario Hospital Insurance Plan (OHIP).

These and other reports are gradually increasing professional and public awareness of the potential problems posed by the collection and storage of medical information. One group that is very concerned about the relatively easy access of the public to confidential health records is the Canadian Health Record Association. At its annual meeting held in Ottawa this past October, the association adopted a position statement on confidentiality of health information and a Code of Practice for Safeguarding Health Information. (see box)

In its position statement, the CHRA stated that "the growth of computerized health data processing systems and the advancements in health record linkage pose a potential threat to the privacy of health information. The CHRA is concerned about the serious consequences of any loss of confidentiality in health care systems." It pointed out that

"many persons handle health records and information without realizing fully the need for confidentiality... Electronic information processing organizations, microfilming companies and transcription services may expose health record personnel who are not aware of the patient's right to privacy."

The Canadian Health Record Association, composed of more than 3,000 health record administrators as well as medical, paramedical and non-medical people working with health records and statistics, believes that widespread knowledge and application of the ten principles in the Code of Practice will effectively help to prevent many breaches of confidentiality now and in the future.

The association's provincial presidents have presented the code to ministers of health in each province and members of the association have distributed and promoted the code in the hospitals and medical clinics in which they work.

The code committee discussed the project with officials and executives of the Department of Health and Welfare, the Canadian Medical Association, the Canadian Hospital Association, the Canadian Nurses Association, the Health Computer Information Bureau, the Canadian Organization for the Advancement of Computers in Health, the Canadian College of Health Service Executives and the Canadian Public Health Association. The code has been distributed to officials of OHIP, police forces across the country, insurance associations, children's aid societies, banks, credit unions, social workers, consumer associations, some private investigation firms, law associations and schools.

Code of Practice for Safeguarding Health Information

This code of practice is for the guidance of all persons in Canada who handle and have access to health information and records.

The underlying principle is that all health information related to an identified individual must be treated as confidential. This information may be in written, verbal or other form.

The primary purposes of the health record are:

- i) to document the course of an individual's health care, and
- ii) to provide a means of communication amongst health care professionals for current and future patient care.

The Code of Practice is not meant to impede in any way the use of health records for educational purposes, legitimate research, quality care evaluation and epidemiological investigations. It acknowledges the need to use portions of these records for proper substantiation of claims for payment.

1. All individuals, institutions and organizations maintaining, handling or processing health information shall:
 - a) have written policies regulating access to, release of, transmittal and destruction of health information;
 - b) educate all their employees with regard to maintaining confidentiality of information, and have them sign a *pledge of confidentiality*. This procedure shall apply also to researchers, volunteers, contracted individuals and employees of firms and corporations performing contractwork.
2. Health information shall be accessed or released only for:
 - a) direct care use — when requested by a physician or health care facility responsible for the direct care of the individual;
 - b) individual use — when authorized by the individual or his legally authorized representative;
 - c) secondary use — when requested by properly authorized persons or agencies;
 - d) legal use — when required by law.
3. Requests for confidential information should be in writing; however, policies governing verbal requests shall be as outlined by the individual institution.
4. Any authorization for release of information shall be an original and specific as to: source, content, recipient, purpose and time limitations. Reproductions of original signatures shall not be accepted.
5. Information released to authorized persons shall not be made available to any other party without further authorization.
6. Health information and records shall be kept in a secured area and not left unattended in areas accessible to unauthorized individuals.
7. In research, individual confidentiality shall be maintained in the handling of information and any reporting or publication of findings.
8. When health information is sent to any service organization for processing, the contract shall include an undertaking by the recipient that confidentiality will be maintained.
9. The authorized destruction of health information shall be by effective shredding, burning or erasure.
10. Any misuse of health information shall be reported to the responsible authority.

Show me

Diana Gendron

Sometimes, deciding what a patient **SHOULD KNOW about his own health care is not nearly so hard as determining what that particular patient **ALREADY KNOWS** about how to handle his problem.**

Learning is a highly selective and subjective process. We all learn what we feel we need to know and, when we learn, we build on what we already know, interpreting the information that we receive in the light of our past experience, values, goals and motivation. That's why, as would-be patient teachers, our first step must always be to find out as much as we can about what our patient already knows about his illness and how to care for himself. The more accurate our interpretation of what an individual patient needs to learn, his willingness and ability to learn, the more effective the education process is bound to be.

There is so much that we would like to teach patients but only some of this knowledge is relevant in terms of the individual situation of each patient. In order to be effective health care teachers, we must learn to be realistic, discriminating and, above all, selective in what we teach.

It's a lesson that begins in school and, in my teaching, this is the way I have approached it.

A play in two parts

The actors in the following two-act role play are small groups of students just beginning their clinical experience on a medical unit. As their instructor, I assume the role of the patient, Mrs. Wilson, a diabetic. The purpose of the exercise is to illustrate two different methods of assessing a diabetic patient's knowledge of insulin administration and to facilitate a discussion of the process of critical thinking in patient care.

As the patient, Mrs. Wilson, I am programmed to demonstrate a number of non-ideal aspects of knowledge and performance, providing that the student who assumes the role of nurse elicits these responses during the questioning.

Act One

The setting: Act One takes place in Mrs. Wilson's room in the hospital on the day she is scheduled to be discharged.

The patient: Mrs. Wilson is a 70-year-old retired school teacher, a widow who lives alone in an apartment. She has been diabetic for 20 years and is currently hospitalized for an infected ulcer on her foot. The infection has now been resolved, and Mrs. Wilson is to be discharged home today. A visiting nurse will be coming to her home to help her with sterile dressings for her foot.

Mrs. Wilson has been on insulin since her diabetes was diagnosed and is now on 25U of NPH insulin each morning. This is the same dose she had been on at home. While in the hospital, she has asked the nurses to give her insulin in her arms in order to give her usual injection sites a rest.

The nurse: Pat is a new graduate who has Mrs. Wilson in her assignment for the day. This is the first day Pat has been on this nursing team and she is not familiar with the patients. The team leader gave Pat the above information about Mrs. Wilson. It has been a hectic day, but now after lunch things are quieter. Mrs. Wilson is to be discharged in about an hour. Pat has been over foot care with her and arrangements for the visiting nurse seem to be completed. Since there is a short time available, Pat decides to talk with Mrs. Wilson about her insulin administration.

The audience: The student who will assume the role of the nurse is asked to go out of the room and take about ten minutes to jot down things she would like to ask Mrs. Wilson about insulin administration. While she is gone, the rest of the student group is given the following four questions to think about as they watch both acts of the role play:

1. What type of questions does the nurse ask, and what information is gained as a result?
2. What assumptions does the nurse make about Mrs. Wilson?
3. What areas can you identify as needing some change in Mrs. Wilson?
4. What factors would you consider in approaching her in the areas of change you identify?

The play: The student playing the role of Pat is called back to the room and Act One begins. In each of the five times that I have used this role play, the types of questions Pat poses to Mrs. Wilson are primarily factual ones such as: "Could you tell me your type and dose of insulin now?" "How do you rotate sites?" "What do you do if you have an insulin reaction?"

Mrs. Wilson's responses all indicate a good knowledge of insulin administration. After a period of interaction, Pat and the rest of the student group usually conclude that Mrs. Wilson's knowledge is quite good. Indeed, the context of Act One has been structured so as to promote the type of assessment which would result in this conclusion. Act One ends.

Act Two

The setting: Mrs. Wilson is now at home where she is receiving a visit from Jane, her visiting nurse. Jane has asked Mrs. Wilson about her ulcer and discussed foot care with her and now she decides to talk with Mrs. Wilson about her insulin administration. The same student who assumed the role of Pat in Act One continues in the role of Jane in this act.

Show me: This time the questions that the nurse poses are derived from an assessment guide on insulin administration (see figure one) that she is given at the start on the role play.¹ Some of the questions on the guide can be answered orally but the majority of them require the patient to "act out" the answer. These are the "show me" questions; they involve performance by the patient of some activity related to insulin administration or use of the actual equipment the patient has on hand.

Because of time limitations, the student is directed to confine her questions to those set out in the guide. What follows are a couple of vignettes from actual classroom experiences.

Vignette One

Jane: "Could you show me your insulin supplies."

Mrs. Wilson: "Sure. Here's my cupboard with all my equipment together. I have my U 100 syringe here; also my old U 40 syringe is right next to it. Things keep changing, so I thought I'd save it in case the insulin strengths are switched back again. It's still quite a good syringe."

Jane: "Yes, the U 40 syringe does seem of good quality. When the two syringes are side by side, however, it seems it would be easy to get the U 40 syringe confused with the U 100 syringe by mistake."

Vignette Two

Jane: "Could you show me how you draw up your insulin."

Mrs. Wilson: "O.K." (Patient draws up the insulin and presents the syringe to Jane. The syringe is almost half filled with air.)

Jane: "There's still quite a bit of air in the syringe."

Mrs. Wilson: (Looking intently at the syringe) "I don't see any air."

In the process of "showing" Jane the answers to some of her questions, Mrs. Wilson reveals a number of other questionable or non-ideal practices. It appears, for example, that, in spite of the fact that she seems to have vision problems and that her insulin dosage is an odd-numbered one, she uses a glass syringe marked off in even-numbered units of insulin. When Jane asks her to demonstrate how she gives her injection into a rolled abdominal pad, Mrs. Wilson does not swab the skin prior to injection of the needle. She also reveals to Jane that she has not found a friend or relative who could give her her insulin and that she is unwilling to take this step. Jane tries to explore some of these non-ideal practices with Mrs. Wilson who seems to have a reason for most of them. She explains, for example, that, "I'm not sure swabbing makes much difference.

I've never got an infection yet." When Jane draws her attention to the air in the syringe, Mrs. Wilson is somewhat disturbed that she cannot see it. As additional aspects of her performance are corrected, both Jane and Mrs. Wilson begin to feel that Jane is whittling away Mrs. Wilson's self-confidence. Mrs. Wilson concludes, somewhat defeated, "I'd thought I knew what I was doing, but I guess I don't."

Instant replay

In my role as Mrs. Wilson, I often express my thoughts and feelings more openly than most patients would to a nurse but, at the same time, I make a real effort to react realistically to Jane's approaches and comments.

During the discussion that follows the role play, I question Jane about her feelings during Act Two. The most common reaction is a feeling of frustration; Jane wants to correct Mrs. Wilson but is conscious of the patient's growing resistance and the attitude of defeatism that is beginning to be evident. Sometimes the student who is playing the role of Jane feels threatened and reacts defensively when Mrs. Wilson challenges her on some of the practices that she advocates.

I find this a good aspect to study since the knowledge these students have about diabetic care at this point is based primarily on their reading about traditional "ideal" care in a textbook. Sometimes Mrs. Wilson actually has more up-to-date information than they do. When, for example, Jane sees the insulin bottle in current use being stored in the equipment cupboard, she reminds Mrs. Wilson that all insulin should be refrigerated. Mrs. Wilson replies that the pharmacist told her it was okay to keep one bottle on the shelf (a practice that is supported by current research).² Jane is a bit disbelieving and tells Mrs. Wilson she should check again with the pharmacist.

Discussion of this aspect of the role play makes the student realize how awkward she felt during this interchange and recognize her tendency to make Mrs. Wilson be the one to validate the information rather than question her own knowledge.

Report vs. observation

The role play provides a striking example of the different results obtained from two different methods of assessment. In Act One the nurse assumes, on the basis of the report of the respondent (Mrs.

Wilson), that no visual problem exists and that, because she is self-confident and demonstrates good factual knowledge to standard questions about diabetic assessment, there are no areas

of patient health care that need to be changed. The observation-focused assessment in Act Two, on the other hand, permits the nurse to actually study the practices involved and to make a more thorough assessment of the possible teaching needs of the patient. In Act Two the nurse usually assumes that she, rather than the patient, has the best method or latest information about diabetic care.

In this role play, the observation-focused assessment has been structured for the home setting. Although the patient's equipment is more accessible in the home, many aspects of this assessment approach could be carried out in a hospital setting. Patients can be asked to give injections for the purpose of nursing assessment. For many patients, the equipment they use at home can be brought to the

Figure one

INSULIN ADMINISTRATION

Patient's Name MRS. WILSON
Interview Date SEPT. 15, 1978
Interviewed by JANE BAXTER

Doctor's orders: NPH 25U DAILY BEFORE BREAKFAST

Date of order: SEPT. 1, 1978

Ordered by: DR. HILL

1. WHAT INSULIN DID THE DOCTOR TELL YOU TO TAKE? (kind, strength, number of units, timing)

NPH (U 100) 25U, DAILY
BEFORE BREAKFAST

2. DO YOU EVER TAKE A DIFFERENT DOSE FOR ANY REASON?

HIGHER DOSE - PART OF HOSPITALIZATION

3. SHOW ME THE INSULIN YOU HAVE ON HAND.

Kind(s) NPH
Strength(s) U 100
Expiration Date(s) JUNE 1979

4. SHOW ME THE SYRINGE(S) AND NEEDLE(S) YOU HAVE ON HAND.

Syringe calibration EVERY 2 UNITS (EVEN NOS) Needle length 5/8" and gauge 25

5. SHOW ME HOW YOU GET THINGS READY TO TAKE YOUR SHOT.

Soaked in ✓ alcohol Disposable Needle ✓
Boiled ✓ Syringe NO
Technique adequate Yes No
Assembled without contamination Yes No

6. WHAT INSULIN DID YOU TAKE THIS MORNING? (kind, strength, number of units, time)

NPH (U 100) 25U. AT 0700

7. PLEASE DRAW UP THAT DOSE.

Used correct withdrawal technique Yes (No)

8. Amount measured: ABOUT 13U
(If on more than one daily dose, observe measurement of each.)

9. Uses correct injection technique Yes No

10. Injection sites show evidence of good care and adequate rotation Yes No

11. WHAT DO YOU DO ABOUT TAKING YOUR INSULIN IF YOU ARE TOO SICK TO EAT?

ONLY HAPPENED ONCE - YEAR AGO - CALLED DOCTOR

12. WHO KNOWS HOW TO GIVE YOU INSULIN IF YOU ARE TOO SICK TO GIVE IT TO YOURSELF?

NO RELATIVE OR FRIEND

NOT RECEPTIVE TO ASKING ANYONE SHE KNOWS.

Comments

KEEPS CURRENT BOTTLE
IN EQUIP. CUPBOARD
✓ SYRINGE + NEEDLES.

SYRINGE HALF FILLED
✓ AIR. PT. CANT SEE
THE AIR.

DOESN'T SWAB SKIN
FEELS NOT VERY IMPORTANT

hospital by friends or family so that this area of assessment can be pursued with them.

Identifying the changes that are needed

The students identify all the non-ideal elements they perceive in Act Two usually including hazardous equipment and its storage, poor eyesight leading to incorrect dosage, not swabbing the skin prior to needle injection, and not having a neighbor or family member available to give Mrs. Wilson her insulin if she is unable to do so.

The next step is to sift through these areas to identify the factors one might consider in trying to get Mrs. Wilson to change her practices. It has become obvious from Act Two and the subsequent discussion that the repeated bombardment of Jane's corrections as each non-ideal practice emerges is having a detrimental effect on the nurse-patient relationship.

We discuss each area the students have identified as needing change with emphasis on identifying the *risk* in each non-ideal practice. The students are informed that some authorities question the necessity of swabbing the skin prior to needle injection.³ This information provides a more realistic context of controversy related to certain practices which they had assumed were unquestionably necessary for safety.

In addition to the prime factor of risk to safety, the various "mistakes" are discussed in terms of questions such as:

"How does the patient feel about her own practices?"

"Do any of Mrs. Wilson's ideas still provide her with basically safe care although they may not be ideal in terms of the nurse's knowledge and experience?"

"Does the nurse question her own knowledge and judgement as well as that of the patient?"

Using this approach the students consider the fact that Mrs. Wilson does not have a friend or neighbor who can give her insulin. She is reluctant to ask anyone to learn to give her an injection; she feels it would be an imposition on her associates and remarks that: "It's very difficult to stick a needle into someone else when you're not used to it. I wouldn't feel comfortable asking a friend to do that." We discuss how crucial having her ask someone really is. At this point in time, the occasions on which she could not give her own insulin can be predicted to be few. If they do arise, are there not other alternatives one could look at with her in light of the health care support systems in her community?

Mrs. Wilson's visual problems seem the most significant area to pursue in terms of risks to safety and promoting her independence. Thus, when a more thorough examination of the role-play dynamics has taken place, the students can better determine what practices might be more crucial ones to pursue with Mrs. Wilson initially and what areas might be omitted from comment. These lower priority aspects could perhaps be pursued at another time.

Summary

By using a role play with small groups of students, two different methods of assessing a diabetic patient's knowledge and practice related to insulin administration can be clearly experientially contrasted. The method demonstrated in Act One of asking the patient to relate primarily factual knowledge leads to the conclusion that the patient has no teaching needs. When a subsequent assessment is done in Act Two focusing more on asking the patient to demonstrate her practices, a number of non-ideal aspects are revealed.

Observing the role play provides the students with the opportunity to think critically about the "mistakes" they feel the patient is making and the feelings the nurse-patient interaction evokes. They may then look at how to approach the patient, considering their own information, the patient's perceptions of what is safe and convenient, an assessment of the relative risks to safety, and effects of various types of nurse-patient interactions on the therapeutic dynamics.

The students are faced with learning to apply knowledge in a patient teaching situation with very little background from their own experience, making it difficult initially for them to decide which knowledge and practices they have read about are essential and/or the most up-to-date.

The practising nurse can find herself in a similar position because of the rapid expansion of medical and nursing knowledge. As nursing practice becomes more specialized, it is increasingly difficult to keep abreast of current knowledge and the challenges to previously accepted practices in all specialty areas. This, coupled with trying to adapt the knowledge which one does have to the frame of reference of each patient, can indeed present a real challenge in patient teaching. A healthy questioning of our own assumptions and values related to a patient's perceptions and practices seems to be an approach which is very useful in promoting the realistic, discriminating, and individualized care for which we are striving. 4

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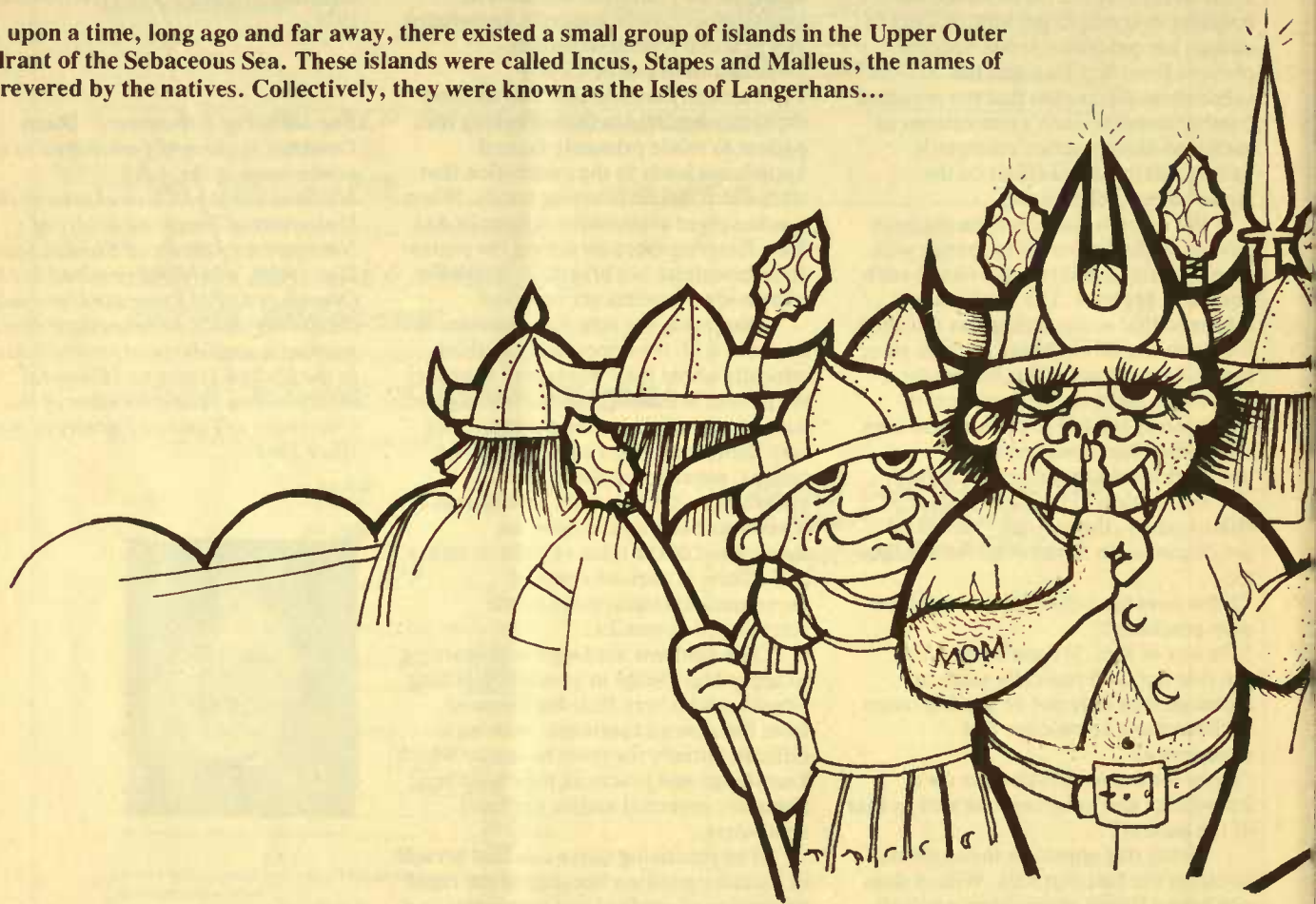
The author of "Show me," Diana Gendron, is currently employed as a senior tutor in the Adult Medical-Surgical Clinical area at the University of Toronto Faculty of Nursing. A graduate of Florida State University, where she received her B.S. (Nursing) and of Syracuse University (M.S. Nsg. Ed.), her experience includes work as a staff nurse at several hospitals in the United States and Canada. Gendron has been a member of the University of Toronto Faculty of Nursing since 1968.



The Tale of the Innominate War

as told by Scott Wraith

Once upon a time, long ago and far away, there existed a small group of islands in the Upper Outer Quadrant of the Sebaceous Sea. These islands were called Incus, Stapes and Malleus, the names of gods revered by the natives. Collectively, they were known as the Isles of Langerhans...



The people who lived on the Isles of Langerhans were called the Synovials, best described in the epic book "The Last of the Synovials", by James Fenamore Cowper. They were clean, just and strong. Subject to Immunity, their King, they led a peaceful life; peaceful, that is, until the nation of Golgi declared war on them.

The Golgi were a short, ill-tempered, myopic, nasty people who reputedly carried on the practice of anabolism. They were abdominal people, the true villi of the story.

The Golgis declared war because of an "inflammatory" remark attributed to a Synovial at the D.B. & C. Conferences (something about their being S.O.B. that was taken the wrong way).

The Golgi Vesicles began the war with Coronal Sutures in charge of the invasion of the Isles of Langerhans. Meanwhile, the good people of Synovial were lying on the beach, listening to Peri Neal on the radio, drinking Pepsin, and having a good time. Suddenly they heard an announcement from their leader, General Malaise — an attack was pending, and he was calling out the Axillary. Major Surgery was indicated as leader of the Costal Defense. The Synovials were preparing for war.

Initially a navel battle was proposed, but the Synovials lacked a large force of Lymph Vessels, so they could only dig in and stay alert.

It was dawn of the following day. The Golgi's Coronal Sutures had only to wait for the high nucleotide to begin the attack.

It was a viscose attack indeed. The Golgi moved in massed peristalsis through the Canal of Schlemm — so-called because of Rear Admiral Schlemm's victorious use of anatomic bombs in Huntington's Chorea — and onward to the main island of Malleus.

The Synovials waiting on the beach were feeling pretty squamous about this time, but remained steadfast of purpose.



The Golgi began firing their ships' guns, until the islands pulsated with great fibroblasts. Quickly they moved in and landed troops on the shore, led by none other than that star of stage, screen and sandy beach, Efrem Embolus Jr. The two armies began to articulate. The Synovials were being pushed back further and further in spite of the unflagging attempts of their Dorsal Planes that were bombing the Golgi by dropping great bundles of his. Their efforts seemed to be in vein.

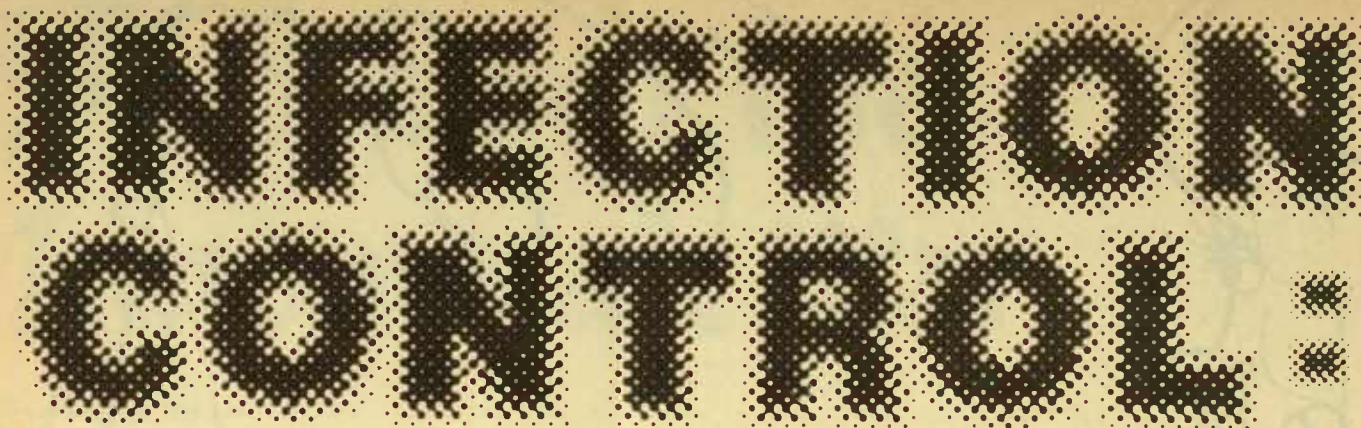
Finally, the Golgi advance was halted on the Sagittal Plain, where a courageous Synovial soldier named Private Parts rallied his troops and set up a counter offensive.

Now the Golgi were in a real neurolemma. They were eventually surrounded and forced to surrender. As a Synovial soldier was later heard to say, "We pulled the ruga right out from under em". Homeostasis had returned. All the captured Golgi were thrown into Schwann Cells.

It is said that the sight of his surrendering army put Coronal Sutures in an aqueous humour. In any event, he took a lethal Bowman's Capsule and died of strabismus.

Major Surgery was promoted to General Surgery; Private Parts was decorated; and everyone lived happily ever after. ♣

Author Scott Wraight is a second year student nurse at Fanshawe College in London, Ontario. Of 'The Tale of the Innominate War', he says, 'I wrote this story as a play on words and it turned out to be a good biology review. The story was written last February when I was in first year. It created a group of supporters who thought I should share it. I hope that you enjoy my efforts and believe that others might too.'



a team approach that really works

In August of 1977, an Infection Control Surveillance Report at a community hospital in Saint John, New Brunswick showed a 19 per cent urinary tract infection rate in patients with indwelling urinary catheters. One year later, the infection rate had plummeted to less than three per cent. Here's how it happened...

Roberta Clark

LeRoy Creamer

Elizabeth Lawson

Paul Tracey

The West Saint John Community Hospital in Saint John, New Brunswick, was originally a veteran's hospital, and its reputation in the area was excellent. In the post-war years, many of the early clinical experiments in antibiotic therapy took place here. In addition, an intern/resident teaching program added prestige to its name.

When it became a community hospital in 1972, its services included most specialties; among them medicine, surgery, urology, rehabilitation and geriatrics. A role gradually evolved in the particular area of chronic care and geriatrics, so that approximately 140 beds were set aside for this purpose. Most of the patients in these areas were level III care; about 90 per cent of them were maintained with indwelling urinary catheters for a period of months or years.*

In August of 1977, our Infection Control Surveillance Report indicated a 19 per cent urinary tract infection rate in those geriatric patients who had indwelling catheters. We already knew that our infection rate was high; our surveillance merely brought it out into the open.

We knew that a five per cent infection rate (based on number of infections and the discharge rate) was a standard rate for active patients, but we were not certain as to where we stood in relation to other hospitals with a similar geriatric population and were unable to obtain papers covering this aspect of gerontology.

We felt, however, that a 19 per cent genito-urinary infection rate on our chronic care and geriatric service was unduly high, and we were certain that with concentrated effort on our part, this figure could be reduced significantly. The Infection Control Committee set out to remedy the situation.

Identifying problems

Our Infection Control Committee was an interdisciplinary group composed of members whose enthusiasm was remarkable. At the direction of the committee, a special meeting of key personnel was called to discuss the situation. Those attending included representatives from hospital administration, nursing administration, the departments of urology, microbiology, infection control and nursing inservice. A number of problems were brought to light at the meeting:

- *Dehydration:* on investigation, patients were found to be quite severely dehydrated. Evidence of dehydration was found in dry mouths, pressure sores, low urinary output and blocked catheters (necessitating frequent catheter changes).

- *Inadequate medical investigation of urinary tract problems:* many catheters blocked frequently. Sometimes they had to be changed as often as twice a week, although the cause of blockage was never determined. Often catheters were inserted initially without determination of the underlying causes of incontinence and without adequate consideration of other measures such as bladder training or condom drainage.

- *Outdated (or non-existent) procedures:* staff had not been provided with information on newer techniques of catheter care and closed urinary drainage systems. Procedures had not been changed in accordance with current information.

- *Use of latex catheters necessitating frequent opening of the drainage system:* the latex catheters in use were actually designed for short-term catheterization (10 days or less) and deteriorated when left in place for long periods of time. Encrustations tended to accumulate on the disintegrating latex wall and proved to be a frequent cause of blockage. The sharp edges of these mineral deposits caused considerable trauma to the bladder and urethral mucosa when catheters were removed or manipulated. Because of these problems, catheters were changed routinely every four weeks. The catheter was indiscriminately disconnected from the drainage system for irrigations, sample taking and even dressing the patient.

*We realize that 90 per cent is a very high rate of catheterization, and we are working hard to reduce the numbers by developing alternatives to catheterization and by removing some established catheters. However, achieving a decrease will take time. In the interim, we feel that our second problem of too many catheters justified a study on how to deal with our first problem of high infection rates in elderly catheterized patients.



Photo courtesy of Sunnybrook Medical Centre

- *Routine irrigations with saline or Renacidin***: methods used to keep catheters patent included daily irrigation with saline to clear accumulations of mucous, or Renacidin to break down precipitate. The irrigations were accomplished by opening the system and irrigating with an irrigation tray and asepto syringe.

- *Reports of specimens frequently indicated that the culture yielded a mixed bacterial flora in excess of 100,000 per ml.*: because we were not sure of the significance of these results, repeat specimens were requested. The repeat specimens frequently yielded information that was equally unrewarding.

- *Inadequate general care of the patient with an indwelling catheter*: staff were not aware of the importance of strict techniques for all aspects of catheter care.

- *Inadequate charting*: no documentation could be found concerning the reasons for frequent catheter change or response to treatments.

- *Unrecognized bacteremia associated with the trauma of catheter change or manipulation*: staff were aware that patients often became ill with symptoms of infection, but they did not associate this illness with catheter change or manipulation.

Our approach

Once the problems were clearly identified, we began an ongoing program to correct the situation. Initially we dealt with two patient units, one for male patients and one for females, each with approximately 33 patients. We felt that a small number of patients could be supervised and controlled more easily. Staff members on the two units were embarked on an extensive educational program instituted by our inservice department and infection control nurse.

At first, we held meetings on the wards with the staff to explain the situation and ask for suggestions. From the information gathered from the staff and from published material, we developed an education program covering such topics as nosocomial infections, improved techniques in catheter insertion and perineal care, intermittent irrigation procedure in a closed urinary system and the importance of fluid intake for patients with indwelling catheters. Our approach incorporated the following changes:

1 Hydration

We aimed to increase the fluid intake of our catheterized patients to 3000 ml per patient per day. This was achieved more readily in some patient areas than others.

When this particular objective was met, we noted a startling reduction in the number of catheters requiring to be changed because of blockage. Naturally, what followed was a similar decrease in symptomatic urinary tract infections.

There were difficulties for the staff as they tried to help debilitated geriatric patients achieve a high oral intake. The two wards developed separate methods to meet this aim. Success depended on the organizational skills, motivation and conscientiousness of the staff involved.

2 Urology consults

Once the 100 per cent silicone catheter and intermittent bladder irrigation systems were in place, the doctor in charge was to be made aware of all catheter changes. Any patient who continued to have urological problems would be referred to the urologist for assessment.

3 Rewriting outdated procedures

Procedures for catheterization and genital care were updated. New procedures were developed to cover intermittent irrigation, closed drainage systems, specimen taking by needle puncture, and general care of the patient with an indwelling catheter. Extensive and intensive education of all levels of staff was initiated before the change over to the new system was made.

**Renacidin is a registered trade mark of Guardian.

4 *Silicone catheters and closed system drainage*

Gradually, we replaced our latex catheters with 100 per cent silicone catheters. We hoped that they would not have to be changed as often and would be less traumatic than the catheters we had been using. The surface of the 100 per cent silicone catheter tends to resist accumulation of encrustations and the large lumen provides better drainage. Before choosing this type of catheter, we did some research. The literature showed that silastic catheters had been used in other centers for long-term catheterization¹, but no length of stay had been established. Together with the urology department, we decided that this would be an individual patient problem — as long as the system functioned well for the individual patient, the catheter would be left in.

5 *Intermittent bladder irrigations*

All routine bladder irrigations with saline or Renacidin were discontinued and each patient was assessed on an individual basis to determine the need for irrigation. We considered that patients who had bladder stones, precipitated debris and excessive bladder mucous required an irrigation system. To maintain a closed system during irrigation, we chose to use a 1000 ml bag of normal saline, cysto tubing and an adapter between the catheter and drainage system. With this apparatus in place irrigation was accomplished using sufficient fluid to fill the patient's bladder. This amount varied from approximately 200 ml for a newly catheterized patient to about 30 to 50 ml for some geriatric patients with severely atrophied bladders. We encouraged the staff to irrigate the bladder and catheter frequently enough to keep the catheter patent and prevent catheter change.

6 *Urine cultures*

Specimens were to be sent for microscopic examination only when the patient was symptomatic. Long-term catheterized geriatric patients show resident polybacteriuria (several bacteria, with an excess of 100,000/ml and the patient asymptomatic).² For our purposes determining the distinction between colonization and true infection was essential.

7 *Improved general care of the catheterized patient*

With education and supervision, the staff became more aware of the importance of care of both the patient and catheter equipment in preventing contamination of the system.

8 *Improved charting*

Staff were encouraged to document specific circumstances of catheter blockage, and response to treatment. Emphasis was placed on the role of the nurse as the individual closest to the patient and thus most able to assess changes in him.

9 *Recognition and prompt treatment of bacteremia*

With education, staff became aware of the signs of septic shock, and its close connection to catheter manipulation. The signs were reported and treatment was started promptly.

Implementing our plans

It took us two months to complete the groundwork including identification of the problems, formulation of an approach and an extensive staff education program. We were then ready to begin testing our system through patient care.

During the next two months, we eliminated routine irrigations and made a gradual conversion to 100 per cent silicone catheters and closed system drainage. An intermittent system was used for patients who were found to require bladder irrigation. The project was under constant surveillance.

The results were exciting. The staff accepted the proposed changes and worked hard to make them successful. Urinary outputs increased, catheter changes were reduced in number and the infection rate went down to 8.9 per cent. It was recommended at a subsequent Infection Control Committee meeting that the program be extended to include the other patient units on the geriatric service.

Prevention

Naturally we were pleased with the decrease in infection rates that we saw in our patients; we had achieved a notable success. Catheters did not have to be changed as often, but when they were changed, or when trauma occurred because of catheter manipulation, we noticed that a clinical genito-urinary tract infection often followed. Too often, this was accompanied by bacteremia. When septic shock occurred, we approached a mortality rate of 75 to 80 per cent.³

Early in our studies, we made three blood cultures a mandatory procedure for anyone with a temperature above 38.5 degrees C. At this stage we were very impressed with the retrospective observation that a great many patients showing elevated temperatures had undergone a catheter change or manipulation within hours of the raised temperature. When we were reasonably certain that the patient had a genito-urinary infection, we started full antibiotic treatment in order to cover the spectrum of gram negative organisms which we were likely to encounter.

A great deal has been written about bladder infection and the multiple growth of gram negative bacteria in the bladder of geriatric patients who have been catheterized for a long period of time.⁴ Our studies indicated that cases of bacteremia were caused when resident bacteria entered the patient's bloodstream. Each incident of bacteremia could be correlated to a catheter change or manipulation. We wondered if prophylactic antibiotics could be used to prevent bacteremia.

We were well aware of the positive results of prophylactic antibiotics in reducing the morbidity rate in gynecological, cardiovascular, chest and bone surgery. As far as we knew, however, no one had published any findings related to the prophylactic use of antibiotics in catheter care for the geriatric patient.

Aware that we were taking a controversial step, we instituted a regime in which we gave two doses of gentamicin 80 mg intramuscularly at the time the catheter was to be changed. Wherever possible, we gave the first injection an hour before the catheter was to be changed; the second dose was given eight hours later. We used the same treatment program whenever catheter manipulation was the cause of trauma as indicated by blood in the urine.

Eventually we reduced the dosage of gentamicin because of our concern about kidney toxicity and ototoxicity in this particular population. Many of our patients had elevated blood urea nitrogen or creatinine levels with decreased creatinine excretion. We calculated the dosage of gentamicin on the basis of 1 mg per kg of body weight, and adjusted this amount according to individual results of kidney function tests. Our microbiology department is carrying on a constant surveillance to detect any signs of resistance to gentamicin.



Photo courtesy of Health and Welfare Canada

High risk urines

A six week program of "high risk urines" similar to that carried out recently in British Columbia was undertaken to determine the type of bacteria present in the bladder and the drug sensitivity of each type. This study included a group of selected patients who were felt to be at high risk for developing urinary tract infections with associated bacteremia.

Weekly urine specimens were sent for culture and sensitivity studies. This program enabled us to keep an eye on current data about the sensitivity patterns of these high risk patients. Because of this program, when the patient experienced trauma related to the catheter, the causative organism and its sensitivity could be more accurately predicted and a better choice of antibiotic could be made. We are now undertaking a second and more specific study in order to:

- determine concentration of bacteria in the bladder, not just identification;
- attempt to determine why only one organism invades the body following catheter manipulation;
- try to determine which bacteria is most likely to invade the body following catheter manipulation;
- determine the sensitivity to a broader spectrum of antibiotics.

Improved care

Since the beginning of our program, the urinary tract infection rate on the geriatric and chronic care services at West Saint John Community Hospital has decreased from 19 per cent of our geriatric population to an astonishing low of less than three per cent. These statistics show that our program's success was remarkable, both from the standpoint of infection control and cost accounting. Control of infection has meant a decrease in the cost of supplies, treatment of infections and staff hours involved.

Our program was ambitious, made possible only through the hard work and persistence of many people. We feel that we have made a big improvement in the quality of care for our geriatric patients.

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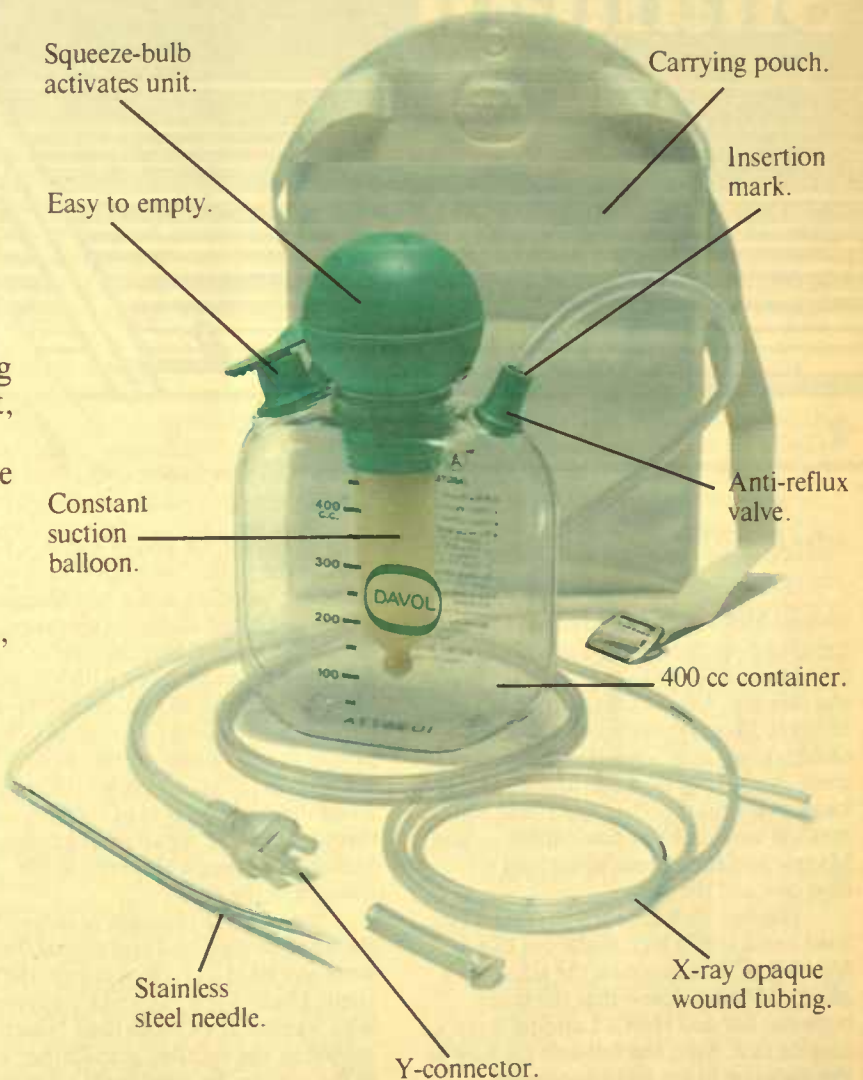
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No Shame for the Shaman



Arlee D. McGee

Maggie McCready stared out at the mist hanging over the rolling hills. "It's not going to be easy to face grandmother," she thought. Life at university had changed Maggie; she was no longer a child taking Gran's word as the gospel truth. No matter how she looked at it she knew that grandmother and the scientific method would not be compatible — and Maggie and the scientific method were now one and the same.

The bus shot forward passing a side road and a sign which stuck out like a hitchhiker. The name on the sign was a blur but Maggie knew that the miles between her and Holt's Landing were closing fast. Still, she felt safe for now so the dialogue in her head continued uninterrupted.

It was not as though she hadn't missed grandmother. Maggie loved her dearly and going away to study nursing could never change that. But something inside kept reminding her that the situation between them could never be the same. She squirmed nervously in her seat. How could she describe the techniques, practices and procedures that she had learned? How could she explain the importance of modern medicine and other therapeutic treatments? Maggie knew all too well that Gran, with years of experience, had her own treatment methods and her own medications.

In her mind's eye Maggie had a clear picture of grandmother's pantry — the

small room off the winter kitchen. One shelf in the pantry was filled with various alchemic wonders and when Maggie was a little girl it had conjured up many mysteries for her. She thought of the familiar Mason jar filled with vinegar, brown sugar and an egg, complete with shell. Gran issued a tablespoon of this potion to any family or friends who complained of respiratory problems. Even the slightest hint of clearing one's throat was a cue for Gran to get the Mason jar. Maggie shivered at the thought of the elixir.

It was more pleasant to remember the dried orange rind and cloves that were stored in a cracked cup on the same shelf. These were chewed by anyone who wanted to sweeten their breath. She smiled as she recalled grandfather's trips to the teacup; he went there after he'd been to the barn. Maggie knew that he hid a "toddy" outside which he said he kept in case he "felt a spell coming on".

The pantry shelf also held a silver tin marked powdered alum. Maggie had often seen Gran sprinkle it on unbeaten egg whites and give it to anyone who had a sore throat. There was a brown package marked sulphur (part of the springtime tonic for fumigation inside and out) and a box of senna leaves for constipation. There was also a crock of nutmegs which Gran would string on a thread and place around the neck of any poor soul who suffered from boils.

A picture of the stainless steel cabinet which contained the medicinal supplies for East Three B stood out in sharp contrast to Maggie's mental image

of Gran's miraculous medicine shelf. For a moment Maggie felt a surge of embarrassment at the thought of the archaic efforts of her own flesh and blood. "Shame on you," she almost spoke aloud. But then again many of the people who lived in the small fishing village might not be well today were it not for Grandmother McCready's skills. Maggie had always known that Gran's ingenuity and special remedies helped the people at Holt's Landing. Whatever the source of her healing powers Gran McCready had a flock of devoted believers.

Gran's patients

Maudie Maxwell was one of the faithful disciples. When everyone else gave up in despair, it was Gran who roasted beef kidneys and applied them warm to the soles of Maudie's feet. Her temperature dropped and Maudie survived scarlet fever without serious complications. It suddenly occurred to Maggie that the value of antipyretic drugs would be of little interest to her grandmother.

There was no doubt, even in Maggie's mind, that Cousin Arnold wouldn't be operating a weir today if Gran hadn't packed cobwebs (gathered from Coughin's barn loft) on his severed foot. As if that wasn't enough she sewed Cousin Arnold's flesh back together. She described it to Maggie once, "A good bunch of stitchery, even if I do say so myself." Gran sutured Cousin Arnold's foot while he sat, white knuckled, on the deacon's bench behind the wood stove in the kitchen.

It would be difficult to convince Gran of the importance of sterile procedures but it would be impossible to inform her of any medical or psychological concepts. Maggie wondered about Marshall Maxwell who wet the bed until he was sixteen. Gran steeped and strained pumpkin seeds and fed the concoction to Marshall everyday. Eventually his bed-wetting stopped. Today a picture of Marshall in his military uniform holds a place of honor on the McCready mantle.

Maggie's mind raced on and she was back with Gran in yesterday's meadows. She could feel her small hand covered by Gran's warm strong fingers as she led the way to the riverbank. Together they searched under the base of the river trees for gold-thread. Later Gran told Maggie stories of the little babies who had a good night's sleep after the steeped gold-thread soothed their mouth infections. Recalling her experience in the hospital nursery Maggie couldn't help but wonder if all of those aseptic techniques were really necessary.

By now Maggie McCready was as totally oblivious to the scenes flashing by the moving bus as the scenery was oblivious to her. Her mind was already at Holt's Landing with Gran. Maggie could picture Grandfather sitting anxiously by the kitchen range, grey-socked feet on the open oven door. He was wheezing like a horse with the heaves. Gran was not idle. She cut strips of cotton and soaked them in strong saltpeter and water. After they had dried she lit a kindling splinter and set the cloth on fire. When Gramps inhaled "enough" of the fumes (and Gran knew when it was enough) Maggie watched the miracle of his natural breathing return. Now that she thought about it Maggie knew she had never seen a respiratory technician bring a patient any more relief.

No one would deny that Gran was Gramp's caretaker. Maggie could still hear Gran ask the local hunters to save their bear fat for her. This was in anticipation of Grandfather's rheumatism. It was a gentle kind of firmness which Gran used when she rubbed the bear grease on Grandfather's joints. The aches and pains were usually worse on rainy days — today, thought Maggie, is a bear grease day.

Gran's concern for the health and welfare of immediate relatives always took top priority. For a minute Maggie thought of little cousin Helen. Everyone was concerned when Helen developed eczema. It covered both of her arms and was itchy and unsightly. Gran treated Helen privately. Some years later Helen confided in Maggie; Gran had given her a little pot and told her to collect a morning specimen of urine. She told Helen to dip her arms in the liquid everyday. Gran was discreet — she didn't tell anyone

anything about Helen's treatment. The only thing most people know is that Gran treated Helen and the eczema cleared up.

As Maggie pondered her Grandmother's treatments she realized the fame of this seaside shaman spread well beyond the boundaries of the family.

It was not at all uncommon for people to drop in to discuss their ills with Gran. Maggie remembered the day that Jim Baldwin was tearing down the pigshed connected to his barn. He stepped on a rusty nail and before the day was over his foot was red and swollen. Maggie saw Gran apply a liberal piece of salt pork to the puncture and secure it with a clean cloth. In a few days Jim reported one hundred per cent results from the pork treatment. Maggie made a mental note to omit a description of the value of tetanus toxoid from discussions with her Grandmother.

Gran's magic touch

Maggie herself had not been exempt from Gran's medicinal magic. Aunt Helen told the story this way: "Baby Maggie had croup so bad that everyone feared she would choke to death. Gran got goose grease from the earthenware crock on the pantry floor and mixed it with molasses. After she forced a spoonful or two into the baby's mouth, up came the phlegm and baby Maggie was as good as new."

Maggie remembered other things and, just for a moment, she could actually feel the hot onion heart which Gran put in her ear when Maggie had an earache. Maggie remembered how good it felt when the pain went away.

Regardless of the help Gran gave her, Maggie was often annoyed and embarrassed by this homespun doctoring. Her nostrils flared as she thought of the camphor cake. Gran secured it in a little flannel bag and Maggie had to wear it around her neck to ward off flu and other germs. No matter how deeply she tucked the camphor bag inside her shirt she knew that her school chums could smell it. Once she was so desperate that she doused herself with Lily of the Valley cologne. Then she realized that, blended with the odor of camphor, it was not a good combination. Maggie felt a twinge of guilt remembering that she really hadn't caught all the other diseases that most of her friends had. Perhaps she could tell Gran what she had learned about prevention, at least it was worth a try.

Maggie's cheeks burned as she thought of the time she flatly refused to drink steeped sheep droppings to help bring out the measles rash. She also remembered that she made up for it later on when she agreed to wear a salt herring on her neck to ward off a sore throat. At

times Maggie was certain that Gran was downright medieval.

The jolt of the bus made Maggie's mind whirl into practical form. She gathered up her bag and purse and left the bus. Weighted feet led her the few yards to the familiar grey house. The curtains moved and she saw Gran peeking out from her seat in the corner of the kitchen. Maggie's feet moved faster. Before she could form any real thoughts she and Gran stood face to face.

"Maggie, my love, how I've missed you. Come, tell your old grandmother everything." The words which tumbled from Maggie's lips formed, not in her head, but in her heart. "Oh Gran, there's so much that I want *you* to tell me." ❖

In a letter to CNJ author Arlee McGee wrote:

I have written this "non-academic" piece as fiction. It is, in reality, a story about my maternal grandmother, Mercedes Keinighan, a Spanish lady who spent many years living in Newfoundland. My mother inherited her "medical genes" and passed them on to me.

Rural maritimers still use some of the folk medicine my grandmother advocated. They feel more comfortable with the 'old school' methods. No doubt westerners have their unique treatments too.

We, in the nursing profession, often find ourselves caught up in academia — disassociated from all that which is real. Those of us who administer to the sick often forget the influence of our own unique cultural backgrounds and in so doing neglect to consider those of our patients.

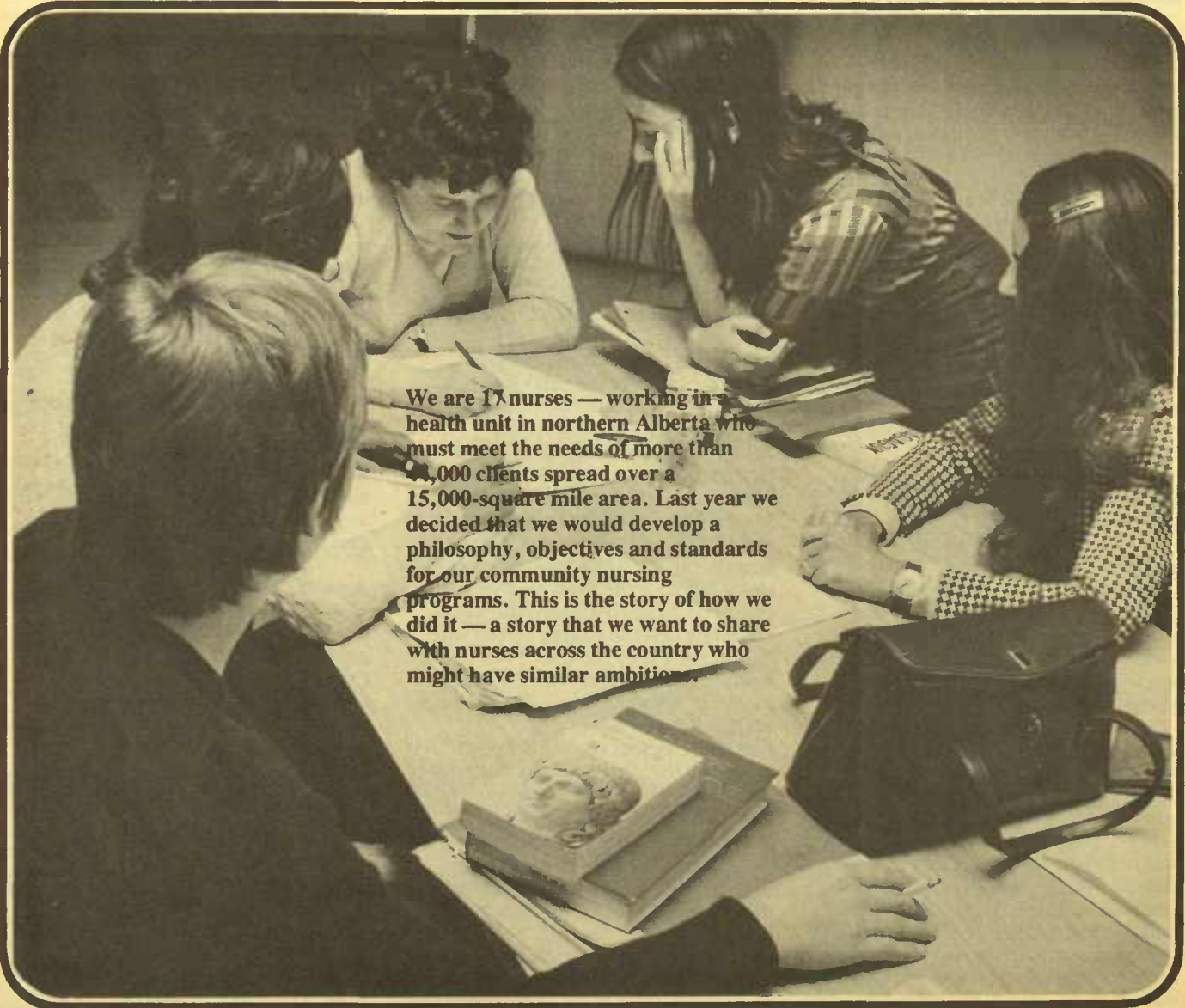
How easy it is to frown in dismay at any kind of "unscientific" healing. We have to remember that judgement of what is right or wrong is not the significant factor — understanding is the key to the door which leads to better nursing care.

Arlee D. McGee, R.N. (Victoria Public Hospital, Fredericton, N.B.) B.N. (University of New Brunswick) is the coordinator of an Alcohol and Drug Crisis Centre — Elm City Foundation — in Fredericton, New Brunswick. This Fall, Arlee was appointed to a four-year term on the N.B. Alcoholism and Drug Dependency Commission. She has since become a member of the Executive of the ten-member Commission which is chaired by Dr. G. Everett Chalmers.

Arlee has had a wide range of experiences in nursing including general duty, public health and psychiatric nursing. Arlee has written three other articles for The Canadian Nurse, the most recent being "Games Nurses Play" (July/August 1978).

We did it. You can too.

Jane Knox



We are 17 nurses — working in a health unit in northern Alberta who must meet the needs of more than 24,000 clients spread over a 15,000-square mile area. Last year we decided that we would develop a philosophy, objectives and standards for our community nursing programs. This is the story of how we did it — a story that we want to share with nurses across the country who might have similar ambitions.

Why did we decide to develop a philosophy, when for years our health unit, like many others in Alberta and elsewhere in Canada, had managed without one? Well, times are changing. Health professionals today are searching for new challenges. Our clients are changing too; they are becoming sophisticated health care consumers. Community health nurses like ourselves are looking for a role that is unique among the proliferation of community workers.

Until recently, the changes that have taken place within the health care system have been gradual. In the community, health workers directed their efforts towards two major problems — polio and tuberculosis — with notable success. Members of the public, lulled by the benefits of "free" medical care, were not inclined to question the status quo. Little effort went into questioning or defining the nurse's role in this slowly evolving system. There seemed no need to defend nursing practice when no one was questioning what we were doing.

But lately, there has been pressure from all sides to move ahead more quickly. We must meet the needs of the community, give our community health nurses "job satisfaction", and, above all, in the scramble for a fair share of today's devalued dollar, stay within our budget.

The pressure for change is irresistible although its direction is as yet unclear. That is why the time to bother about a philosophy is NOW!

Bother with a philosophy for your agency so that board members as well as staff are encouraged to re-evaluate what they believe about their work. Bother with a nursing philosophy developed by staff so that nurses, no matter what their experience or education, can renew their belief in themselves as caring professionals. Bother with objectives to give direction to the decision-making which besets us as we struggle to meet the demands of a rapidly changing and budget-restricted health care world.

Bother with standards not only to tell us how to proceed but also to help us identify those tasks which truly require nursing skills.

If we do not bother now, we will have no answer for the questioning consumers and concerned politicians who knock on the door of our health care world and ask: "What are you doing? Why are you doing it? Is there someone less skilled, less expensive, who can do that task? Is it really necessary at all? Are you really necessary?" If we can only answer, "Well..., we've always done this and...er...it seems to help", we are in trouble. If we cannot state clearly WHAT is our unique role and WHY it is important in today's society, then we are in trouble.

Where to begin

The time to bother is now and the way to begin is by:

- taking time to suggest that your agency identify or clarify its philosophy and objectives before proceeding with the important work of evaluating programs.
- involving the medical officer of health in your plans.
- checking with staff members to ensure that all aspects of their work can be related to your agency's philosophy in a very specific way.
- obtaining the approval of your Board of Health...you'll be surprised at their interest.

At this point, if you have not already done so, it is a good idea to define your terminology. Can you clearly and succinctly explain what you mean by philosophy, objective, standard? Have you decided what kind of standards — structure, process, outcome — will be most appropriate for your agency?

Now you're ready to begin. You've reached what is likely to be the critical point in your program. You must convince everyone on your nursing staff that the task you are about to undertake is worthy of their efforts and their support. You must convince each one of

them individually that they will gain something, that the development of philosophy, objectives and standards will be a personal growing experience. Quite possibly, you will even be able to convince them that they will enjoy it! The involvement of each staff nurse is crucial if the development of standards is to have impact on future nursing practice.

Zeroing in on the problem

Although beginning with an overall philosophy may seem logical, it is likely that many nurses will see this as a vague, far-away, unattainable goal that no one feels willing to tackle. Since it is vital that nursing staff feel comfortable, begin with the known, the understood. Plan for initial success by starting with a specific, well developed and clearly defined program area.

Our nursing staff chose to begin by developing objectives and standards for the post natal home visiting program. Working in groups of two to five, with a target completion date to aim for, they shared what they believed about the post natal visit including the how and why of what went on during these visits. Much lively discussion followed. Nurses often expressed surprise at what their colleagues were doing or were not doing, as the case might be, and considerable time was spent convincing each other of the importance of various ideas and behaviors. At this point in time, a well equipped library is essential so that nurses can use current literature to prove their point. Nurses need encouragement to take whatever time is required to complete this process. Three to four hours per program is not unusual.

The group, as a whole, will want to review each other's work, choosing the most clear and concise description of the essential ideas. Be aware of the general content of each statement to ensure that it fits the definition for objective or standard. When the ideas of everyone in the group are set down in a consistent, orderly format, the results of the teamwork will be evident and impressive.

This is the time when the nursing supervisor may wish to get group approval for the addition of ideas that might have been missed. Earlier participation of supervisory personnel could stifle the sharing of beliefs and/or decrease the efforts of individual nurses to search out literature supporting their beliefs. Although this participation must be well timed and controlled to avoid interference or disproportionate influence, it is nonetheless of vital importance. The staff nurses who are involved may take for granted ideas which they feel are self-evident, for example, explanation of procedures, or they may unconsciously omit aspects of

PHILOSOPHY

Statement of belief describing why.

OBJECTIVE

Desirable goal providing direction for action.

STANDARD

Statement of degree of excellence which is understandable, achievable, measurable.

Structure standards: measurable description of conditions under which it is likely that good nursing care will occur (resources, etc.).

Process standards: measurable description of desired nursing behaviors and activities.

Outcome standards: measurable description of alteration in health status of client as a result of goal-directed nursing care activities. (Difficult to identify clearly which changes are the result of community nursing contribution only.)

their work which they don't enjoy, for example, documentation.

This is also the time when the nursing supervisor has an opportunity to let the nursing staff know that their efforts are appreciated, that the ideas they have put forward are valuable and that the whole team is making recognizable progress toward its goal. Encouragement and support are especially important for nurses who have never before attempted to state their beliefs in written form. They are revealing a part of themselves that they have not previously shared with their peers, and understanding their hesitancy will go a long way towards encouraging further efforts.

At this point, each nurse will want to receive a typed copy of the group's work to date. By stamping each of these copies DRAFT, the nursing supervisor can create another opportunity to encourage the participation of individual nurses and demonstrate that it is the contribution of the group as a whole that will determine the success of the project. A note can be attached to each draft copy thanking each nurse for her efforts and encouraging detailed review to search out inconsistencies, awkward wording, misrepresented or missing ideas. Responses can be requested within a two to three-week period. Prompt circulation of a revised draft that incorporates these suggested changes will again emphasize the importance of individual contributions.

Success

Proceeding in this way, our nursing staff worked on one program per month

throughout the winter months. By early Spring our confidence had risen and each small group began to look at the program of their choice. A committee of five, including the supervisor, was set up to review the drafts as they were completed to ensure consistency, completeness and concise wording. With the assistance of this committee, the supervisor drafted structure standards for each program, describing the optimal conditions that were realistically possible. Revised drafts and structure standards were then circulated to all nursing staff and the Medical Officer of Health with the request that suggested changes be submitted within two weeks. The committee reviewed these carefully and made the appropriate final revisions. Our final product was a booklet that we presented to each nurse on staff.

We were proud and satisfied. We had started from scratch and, in less than a year, had developed a philosophy, objectives and standards for all of our community nursing programs.

What can others learn from our experience? We think we proved that the development of a nursing philosophy is a realistic goal for any group of concerned and committed nurses. We not only accomplished what we set out to do but, in the process, achieved a great deal of satisfaction from the participation and involvement of the entire staff.

Why not start now? Then, you'll be ready when consumers and politicians question YOUR worth.

Reaffirm WHY and HOW nursing can and does have an impact on society.

We did it. You can too! ♡

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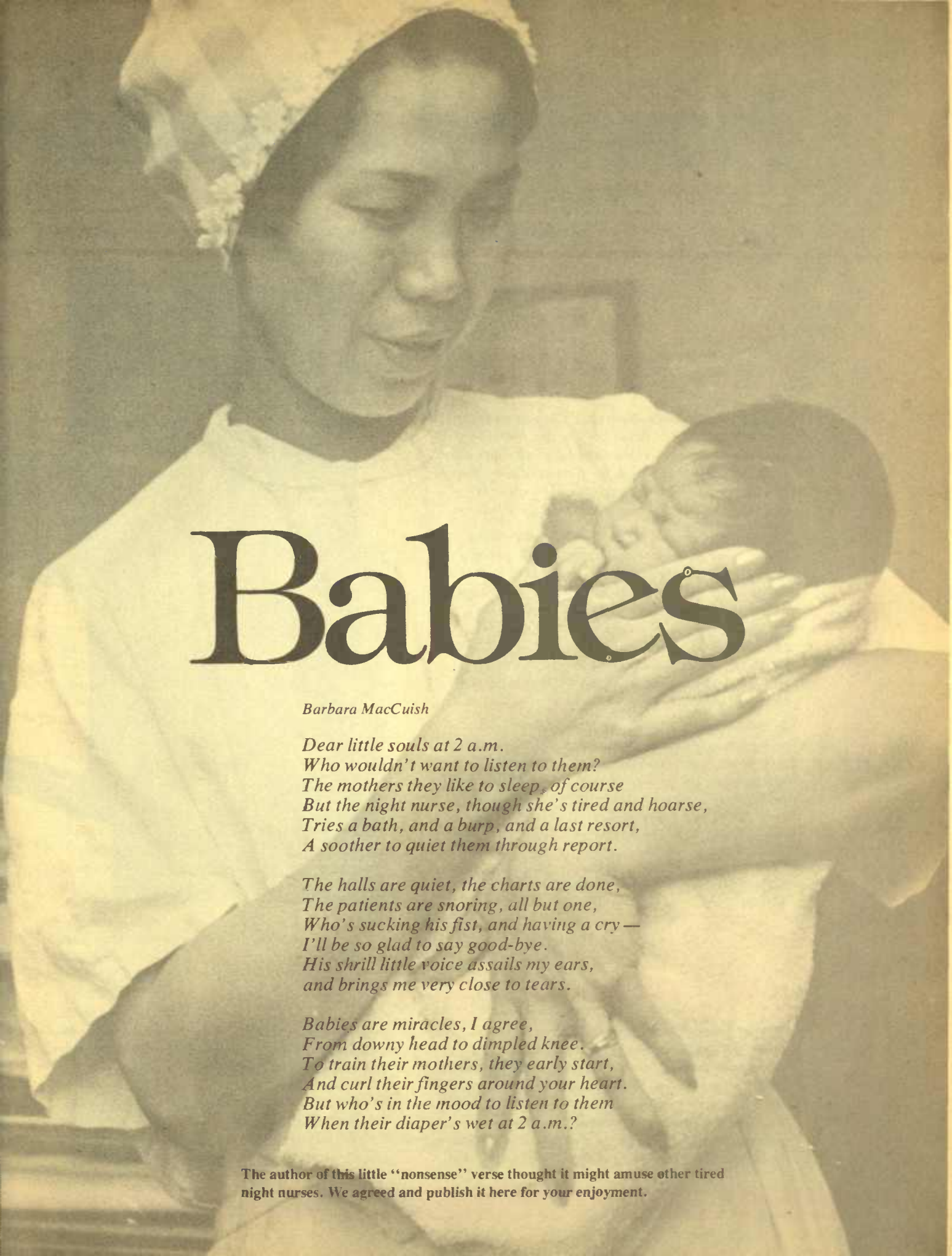
Jane Knox completed a five year B.Sc.N. program specializing in community health in 1971. She worked as community health nurse in Brockville and London, Ontario and taught pediatric nursing at the University of Saskatchewan. Currently she is nearing completion of a B.A. in political science, is active at the local and provincial level in Alberta Association of Registered Nurses and has recently completed a research evaluation proposal regarding the effect of Home Care on community health nursing.

The Grande Prairie area encompasses much of the beautiful Peace Country, with its rolling farmland surrounded by the forests of northern Alberta. The city itself has a population of close to nineteen thousand and is rapidly becoming the cultural center of the north. Recreation facilities are abundant and readily accessible. Daily flights and buses make the community less isolated than might be expected considering its location 285 miles northwest of Edmonton.

As Nursing Supervisor of the Grande Prairie Health Unit, Jane believes in participatory democracy as a management tool and involves nursing staff in decision making whenever it is realistic to do so. In particular, staff nurses, or a representative committee, are involved in decision making which will directly affect their work. This approach makes possible an improved level of nursing care to which all can feel committed. It also provides opportunities for nurses to experiment with nursing leadership roles thus enabling them to expand their personal and professional skills within their normal work situation. She believes this approach helps nurses to feel confident in their own judgment and skills and aids them in setting realistic goals for their work and their professional development.

Tips for Developing Philosophy, Objectives and Standards in Community Health Agencies

1. Involve your medical officer of health.
2. Obtain the approval of your board of directors.
3. Define your terminology.
4. Involve ALL nursing personnel.
5. Begin wherever nursing staff feel knowledgeable and comfortable.
6. Work in small groups.
7. Establish realistic deadlines for each task.
8. Provide positive feedback.
9. Encourage individuals to review and comment on work.
10. Have a small volunteer committee do the final revision.



Babies

Barbara MacCuish

*Dear little souls at 2 a.m.
Who wouldn't want to listen to them?
The mothers they like to sleep, of course
But the night nurse, though she's tired and hoarse,
Tries a bath, and a burp, and a last resort,
A soother to quiet them through report.*

*The halls are quiet, the charts are done,
The patients are snoring, all but one,
Who's sucking his fist, and having a cry —
I'll be so glad to say good-bye.
His shrill little voice assails my ears,
and brings me very close to tears.*

*Babies are miracles, I agree,
From downy head to dimpled knee.
To train their mothers, they early start,
And curl their fingers around your heart.
But who's in the mood to listen to them
When their diaper's wet at 2 a.m.?*

The author of this little "nonsense" verse thought it might amuse other tired night nurses. We agreed and publish it here for your enjoyment.

New and recent titles

Atlas of Diagnostic and Therapeutic Procedures for Emergency Personnel

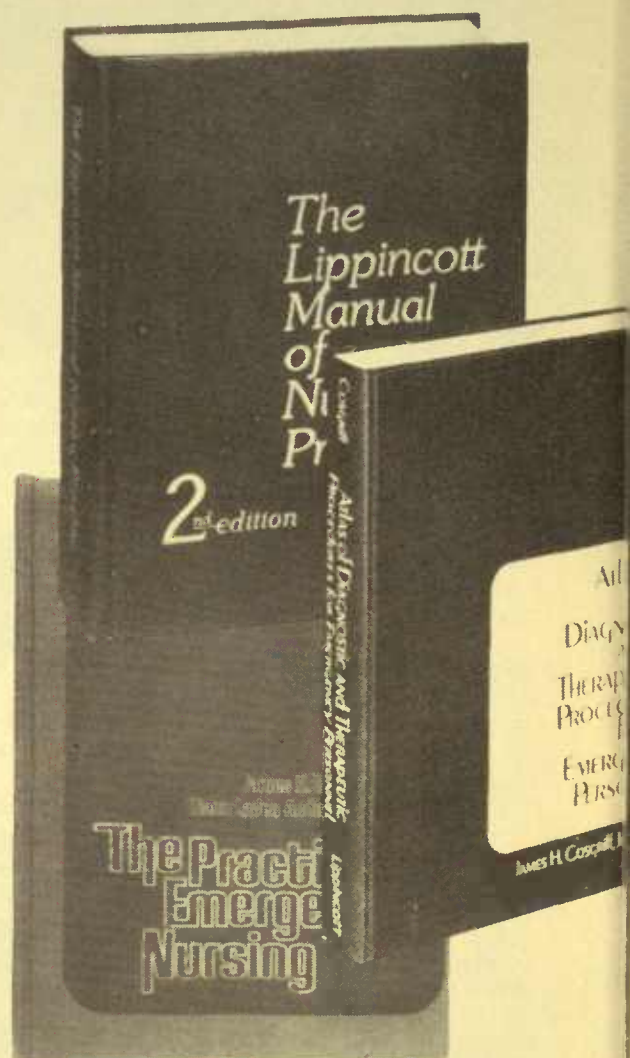
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Failure to thrive

Photo courtesy of Children's Hospital of Eastern Ontario

From the time of his birth, an infant's greatest need is for close, consistent contact with one person. When this need is not met, the infant or child may fail to grow and develop to his potential. Nurses who deal with families with young children are in a good position to assess the mother-child relationship and through early intervention to prevent serious growth and developmental problems in the child.

Jeanette Funke-Furber

Cheryl Roemer

The relationship that evolves between a mother and her child is one of the most important variables in a child's early development. In the first few months of life, an infant needs a stable and stimulating environment, one in which he feels safe and loved. This happens only in a harmonious or synchronous mother-child relationship.¹ In the safety of this relationship, the infant will develop and grow to his potential.

As knowledge of infant behavior expands, however, it is evident that the development of a harmonious mother-child relationship does not always occur. If for some reason a mother-child attachment is asynchronous, the infant may show signs of "failure to thrive". This syndrome identifies those otherwise healthy children and infants who experience growth and developmental failure due to a psychosocial disruption in the mother-child relationship.²

The only universal criteria used to assess failure to thrive (FTT) is a child's weight gain. An FTT child will be below the third percentile on a standard growth chart. Other assessment criteria which may be used include height below the third percentile, developmental lags and autoerotic behaviors.³ Typically, FTT children show rapid weight gain when placed under adequate alternative care such as hospitalization. But adequate weight gain without improvement in the mother-child relationship is not enough to solve the problem in the long term.

From the very beginning of contact, the assessment of a child with growth

failure should include an examination of psychosocial factors and possible family disturbances. One of the difficulties associated with early detection of failure to thrive is that it is often masked by organic problems such as anorexia, vomiting, diarrhea and infections, any of which may cause a growth failure but may themselves be the result of failure to thrive.

The etiology of FTT is not clearly understood but it does appear to involve a complex interaction of physical, nutritional and psychosocial factors. At present, no one can say for sure whether a child with failure to thrive:

- refuses the food offered to him
- experiences emotional disturbance in metabolism or
- is not offered adequate food by his mother.⁴

However, whether the actual growth failure results from inadequate calories, deficient absorption or neurohormonal effects on metabolism, the underlying social and emotional disorders in the family are the primary cause and must be included in the planning of nursing care.

Nurses in a variety of health care agencies are in close contact with families and therefore in a unique position to assess whether or not healthy family relationships exist. Alert nurses who are cognizant of predisposing factors and early manifestations of failure to thrive will be able to intervene at an early stage.

Maternal and family characteristics

Researchers have found a number of factors that have some predictive value in identifying children who may develop failure to thrive. Five factors relating to maternal and family characteristics are particularly significant as identification factors:^{5,6,7}

- In almost all instances of FTT, the pregnancy was both unplanned and unwanted.
- The mother was usually a multipara who had had at least three children in rapid succession, with the failure to thrive child being the youngest. This factor is especially important since we often expect that "experienced mothers" will have much less difficulty adapting to a newborn than first time mothers.
- Generally, the mothers of FTT children had poor experiences with their own mothers and did not perceive their own childhood as a happy experience.
- Furthermore, at this point in their life, these mothers were receiving little or no support from any meaningful adult. The husband was often perceived by the wife as being "symbolically absent".⁸
- The families were often described as being "multi-problem" families with marital and financial problems heading the list.

In a failure to thrive situation, the typical picture of a mother-infant interaction is one of infant neglect, rejection and isolation. Only occasionally are physical abuse or intentional malnutrition part of the picture. The mother may display open or disguised hostility or indifference towards the child. Deprivation may be due to a distortion in the mother's perceptions of her child, resulting in the child's needs not being met.⁹ For example, the mother may interpret cues from the infant that indicate a need for suckling or cuddling as hunger cues. Or, she may have developed little emotional involvement with her infant resulting in sensory, tactile and play deprivation.

Fischhoff, Whitten and Pettit conducted a thorough evaluation of 12 mothers with FTT children.¹⁰ Although the small sample size makes it impossible to generalize, their findings are important and tend to reflect the experience of many other professionals with mothers of FTT infants.

The study showed that the majority of mothers exhibited behavior highly indicative of character disorder, including:

- desire to have an anaclitic relationship (i.e. a relationship characterized by an intense need to be taken care of)
- literal, concrete thinking with poor ability to think abstractly or develop long term plans
- a predisposition toward acting or acting out
- use of mechanisms such as denial, isolation and projection.

Infant characteristics

Infants are born with temperamental differences and this may effect their vulnerability to failure to thrive. These differences can be readily observed in their responsiveness to others, and in their perceptual, effector and signalling behaviors.¹¹ The nature of an infant's behavior, coupled with his mother's response plays a crucial role in determining whether or not a synchronous relationship develops.^{12,13} Do not underestimate the effect that an infant's behavior has on his mother and on their interactions with each other. An infant who shows signs of impairment of any of the five reflexive behaviors¹⁴ (sucking, crying, clinging, eye-following, smiling) or who is difficult to cuddle or console can influence the mother's feelings of adequacy in relation to her mothering skills. Some infants are less

predictable than others in their behavior; others are unable to elicit appropriate maternal responses. Any of these behaviors could contribute to the development of a disruptive attachment bond between the mother and infant. It should be noted also that premature or ill infants show a higher incidence of failure to thrive.¹⁵ In these cases, it is unclear whether the central contributing factor is the early mother-infant separation, the physiological problems of the infant or a combination of the two.

Potential long term effects

To date, comprehensive follow-up studies of FTT children, both individually and as a part of a family system, are lacking. One researcher has followed FTT children from six months to seven years of age and found a striking improvement in their physical, emotional and intellectual growth during the initial treatment period. During the follow-up period, however, the children continued to remain below age norms.

Other studies indicate that FTT children have problems in personality structure and intelligence.^{16,17} These children are often aggressive, have poor control over emotional responses and express negativistic behavior. Socially, they may overconform or express asocial behavior. In the area of intelligence, they often have low IQ scores in verbal and abstract thinking.

Because of the range of factors that contribute to the development of failure to thrive and the long term problems this disorder presents, treatment must include more than just short term hospitalization for the child. The variety of health care settings that nurses work in enables them to play a crucial role in the prevention and, later, treatment of failure to thrive.

Table one

MATERNAL AND FAMILY CHARACTERISTICS ASSOCIATED WITH FAILURE TO THRIVE

- unplanned, unwanted pregnancy
- multiparous mother with at least 3 children born in rapid succession
- multiproblem families
- mother's own experience of being mothered was poor
- mother receives inadequate adult support
- past evidence of emotional instability in the mother
- physical illness associated with pregnancy
- prolonged mother-infant separation at birth

FUNKE'S POSTPARTUM — MOTHER-INFANT INTERACTION ASSESSMENT GUIDE

ACTIVITIES	TOTAL SCORE				
	Least Positive 1	2	3	4	Most Positive 5
Attentiveness, eye-to-eye	Eye-to-eye — en face contact — never occurs between mother and baby.	Mother gives baby eye-to-eye — en face contact, less than one third of the time.	Mother gives baby eye-to-eye — en face contact — over one third of the time.	Mother gives both baby and observer equal amounts (50-50) of eye-to-eye contact.	Mother gives baby almost constant eye-to-eye — en face contact.
Acceptance — rejection	Mother expresses more than 3 problems and/or frustrations, and is grossly dissatisfied with her baby's feeding behavior; openly resentful or rejecting, viewing baby as an interference.	Mother expresses some 2 or 3 disappointments and/or dissatisfactions in her baby's feeding behavior. The baby is not meeting her expectations.	Mother generally expresses neither satisfaction nor dissatisfaction with her child's feeding behaviors.	Mother generally pleased, but concerned: ie. Is the baby taking exactly the right amount, often enough? or baby's not burping well.	Mother expresses great pleasure and satisfaction with her child's feeding behaviors: ie. pleased about amount being taken, baby's sucking and burping.
Physical closeness	Holds the baby approximately 12 or more inches from her own body, or does not hold baby.	Holds the baby approximately 8 - 12 inches from her own body using mostly palms or hands for supporting baby.	Holds the baby approximately 5 - 8 inches from her body, using mostly forearm for supporting baby.	Holds the baby approximately 3 - 5 inches from her own body.	Enfolds baby against her own body, uses entire arm to bring baby close to her.
Speed of response feeding, diapering, cleansing.	No response or responds only after baby has made demands for more than 5 minutes.	5 minute delay in responding to baby's need (i) to be fed, (ii) for diapering, (iii) for cleansing	Inconsistent in speed of response, sometimes immediate, sometimes a 2-3 minute delay in responding to baby's need (i) to be fed, (ii) for diapering, (iii) for cleansing	One half minute to one minute delay in responding to baby's need (i) to be fed, (ii) for diapering, (iii) for cleansing	Immediately responds to baby's need (i) to be fed, (ii) for diapering, (iii) for cleansing.
Sensitivity — insensitivity	Geared exclusively to own wishes, moods; routinely ignores or distorts the meaning of baby's behavior.	Does not see things from baby's point of view, is preoccupied with other things; frequently fails to be aware of baby's cues, mother's perceptions distorted in 3 or 4 aspects. Not consistently insensitive, when baby's moods are in line with mother's activities and moods; or when baby truly distressed, mother displays attunement.	Awareness is intermittent, often keen but sometimes misses both definite and subtle cues; perceptions distorted in one or two aspects, appropriate in others.	Less attuned to more subtle cues, but does not miss or misinterpret baby's overt, definite cues.	Exquisitely attuned to baby's cues: reads cues skillfully, sees things from baby's point of view.
Tactile expression	Touching done in a rough, quick, unaffectionate manner. No display of warmth or affection.	Mother reserved, making no contact with baby outside the necessary handling. (Functional touching only).	Protective touching only; ie. support of head done with little or no affection.	Infrequent expressions of affection only 2 - 3 times during a specific care taking activity.	Openly and affectionately hugs, strokes and often kisses her baby, 5 or more times. (non-functional, protective, functional touching)
Speaking to baby	Mother speaks to her child in a demanding, and/or aggressive and/or rejecting manner during the feeding activity.	Mother does not initiate any comments to her baby during the feeding activity.	Mother speaks to her baby without intonation or inflection in her voice during the feeding activity.	Mother speaks acceptingly and affectionately to her baby 2 - 4 times.	Mother speaks acceptingly and affectionately and directly to her baby 5 or more times during the feeding activity.

Nursing intervention

Primary prevention

At this level, the nurse is in a position to identify those childbearing families where infants may be at risk to develop failure to thrive. Public health nurses and those teaching pre-natal care are in an especially good position to evaluate family behaviors. Pre and post-natal indicators associated with failure to thrive (see Table One) can guide the nurse in her observations and assessments.

Once a family has been identified as having potential problems in this area, the nurse can intervene. Often, the family may lack information about child rearing practices or be ill equipped to handle the changes in family life that occur with the arrival of a new infant. These parents need more information, particularly about the importance of bonding and infant behaviors.

Family members also require the support of significant others both within and outside the family system. Since mothers of FTT children often perceive their husbands as being absent, intervention aimed at helping the husband and wife talk through this problem may be required. Another predisposing factor is the mother's own past experience of inadequate mothering. In this instance, the nurse can play a strong nurturing, supportive role so that the expectant mother will feel secure enough to nurture her own infant. In dealing with multi-problem families, early referral to other agencies in the community will be necessary.

Secondary prevention

When an initial nursing assessment indicates a mild to moderate family problem, secondary prevention should be instituted. At this stage, the infant or child has no overt symptoms such as low weight gain. However, signs of inadequate parenting can readily be identified by observing the mother-infant interaction, especially while the mother is engaged in communicating with or looking after her baby. An assessment tool such as the one outlined in Table Two will be useful in identifying disturbances in mother-infant interaction.¹⁸

At this level of nursing intervention, the goal is to promote positive parenting behaviors and thus prevent the occurrence of physiological symptoms in the child. The first thing the nurse must do is establish a helping relationship with the mother and concentrate on her needs. The mother must feel that the nurse is interested in her as an individual and, then, once a helping relationship has been established, the focus of attention can shift to the promotion of positive parenting behaviors.

Table three

INFANT BEHAVIORS FREQUENTLY ASSOCIATED WITH FAILURE TO THRIVE

0 - 6 months

- withdrawn
- apathetic
- watchful
- anorexic
- minimal smiling
- delayed vocalization
- depressed motor activity
- insomnia or disorganized sleep patterns
- delayed osseous development
- looks younger than age
- developmental lags
- avoids contact; rejects environment
- autoerotic behavior

6 - 10 months

- no stranger anxiety
- no displeasure at parents leaving
- smiles readily
- some initiation of contact
- vocalizations infrequent
- lags in gross motor development
- quiet, undemanding

23 - 27 months

- superficial relationships
- will go with any adult
- aggressive and angry with mom, especially at feeding time
- developmental lags may be evident

Two factors are particularly important in this area. First, the nurse should reinforce and support the positive interactions the mother has with her baby; secondly, teach her new techniques of interacting with her infant. Usually, this can be accomplished in an indirect way if the nurse acts as a role model for the mother, displaying techniques such as holding the child close, establishing eye contact etc.¹⁹

An important part of the nurse's role is to provide parents with information and insight into their baby's reflexive behaviors, needs and temperamental variations. Included in this should be a discussion of the growth and developmental needs of their child. Then, once they are aware of their infant's individual needs, the nurse can suggest ways of establishing parenting behaviors that will meet these needs and decrease some of the frustrations the parents may have been feeling. For example, the nurse can help the mother learn more appropriate ways of managing a sleepy baby, a fidgety child or a slow feeder.

Researchers have indicated that mothers of FTT children often have difficulty in establishing adequate play and feeding patterns.²⁰ In the area of play, the nurse can help the parents understand how important play is for the development of the child. She can assist them in learning how to play with the baby and how to choose appropriate toys and activities for his age group.

When talking to the mother about feedings, the nurse should focus on the *infant's* feeding pattern rather than on the mother's method of feeding. The mother may require specific instructions on how to incorporate her baby's feeding schedule and menu into the family's regular routine. The nurse should also go over the number of calories and the amount of fluid the baby needs.

As the child progresses through the various stages of development, follow-up visits by the nurse who continues to provide anticipatory guidance to the family may be required. At this stage, nursing intervention should be adequate in preventing the development of physiological symptoms in the child.

Tertiary prevention

A child who has been identified as suffering from failure to thrive may already have irreversible damage. (Infant behaviors which are manifestations of failure to thrive during an infant's first two years are listed in Table Three).²¹ At this point, the ultimate goal of nursing intervention is the reversal of the failure to thrive situation. Nursing measures are directed towards promoting an adequate mother-child relationship in an effort to avert and prevent further developmental damage.

There is, however, a high probability that the depriving mother will have a character disorder.²² This type of mother will have a very limited capacity to perceive and assess her baby's needs. She may be inner directed and desire an anacletic relationship with her child, i.e. she will expect the child to meet her needs for dependency. It is quite unlikely, then, that the type of nursing approach outlined in secondary prevention would be successful.

This mother may not respond to verbal discussion and role modeling by the nurse; instead, she may need to be taught to care for her infant in a very direct manner. The mother may require a long term relationship with another helping person who will allow her to maintain a high level of dependency; for example, a homemaker may be the answer.

A child's failure to thrive may be one of many problems a family is facing. In these situations, long term therapy by an interdisciplinary team may be an essential part of intervention. The nurse's role will continue to focus on the mother's ability to adequately nurture her child and to establish good feeding patterns. In addition, the nurse will need to assist the mother in adjusting to the child's changing developmental needs. This can only be done through follow-up visits.

Conclusion

The role of the nurse in the prevention and treatment of failure to thrive has probably been best described by Stewart in the following quotation:

*"The failure to thrive of children without organic disorders is an indictment of society, and yet one that occurs frequently. The maternal deprivation associated with the syndrome is often part of a complex cycle of inadequate mothering breeding a succeeding generation of inadequate mothers. This malady will be perpetuated if professional recognition of a need for help occurs only with a major health crisis. Identification of high-risk families and early therapeutic intervention are critical aspects of health care. Nurses involvement with the situational and interpersonal factors affecting family wellness puts them in a strategic position to help families who fail to thrive."*²³

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Jeanette Funke-Furber (B.N., McGill; M.Sc., U. of Colorado) was assistant professor in the Faculty of Nursing at the University of Alberta at the time of writing this paper. For the past eight years, she has taught in that university's maternal-child health program. Recently, she completed a two-year funded research study project "Reliability and validity testing of indicators of maternal adaptive behaviour". Presently she is conducting workshops and writing papers related to her completed research.

Cheryl Roemer (B.Sc.N., U. of Alberta) has had teaching experience in mental health and in maternal-infant health at both the hospital program level and the university level. At the time of writing this paper, Cheryl was a graduate student (U. of Alberta, master of education program), completing an independent study course under the guidance of Jeanette Funke-Furber. Presently, Cheryl is an assistant professor in the Faculty of Nursing, University of Alberta.

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provides a touch shield or coating that bonds to the skin, sealing out digestive juices or urine, even allowing excoriated skin to heal. This inert barrier protects skin from possible reaction to the adhesive. The single-use wipes are easy to carry in a pocket or purse. Pulling off an ostomy pouch can tear away the outside cornified layer of skin, exposing the tender layer underneath. A SKIN-PREP Protective Dressing "veneer" will absorb and prevent the pull stress normally applied to the top layer of the skin.

SKIN-PREP Protective Dressing may also be used as a protective barrier under adhesive bandages and casts or as a shield for bony prominences (shoulder blades, elbows, hip bones and heels) subject to unusual abrasions which may occur during prolonged bedrest.

For further information contact: United Division of Howmedica, Inc., 11775 Starkey Road, P.O. Box 1970, Largo, Florida 33540.

■ Oilatum Baby Soap

Stiefel Laboratories (Canada) Limited announce an addition to their line of medicated soaps — Oilatum Baby Soap. The soap is made with 7.5% polyunsaturated vegetable oils for a baby's tender and delicate skin.

SASTid Soap is another addition to the line of dermatological soaps offered by Stiefel Laboratories (Canada) Limited. SASTid soap is indicated in the treatment of stubborn acne and contains 10% precipitated sulfur, U.S.P. and 3% salicylic acid U.S.P. in 100 g bars.

For further information contact: Stiefel Laboratories (Canada) Limited, 6635 Henri Bourassa Blvd. West, St. Laurent, Quebec, H4R 1E1.

■ Natural Breast Prosthesis

The Knoche Natural Breast Prosthesis offers high quality and naturalness for women who have undergone a mastectomy. It may be worn with every normal brassiere or bathing costume.



The prosthesis has a marked anatomical similarity to the normal breast; it is natural in size, shape, color, weight, pores, nipple and areola. It is absolutely compatible with the skin, even with radiated skin.

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For further information write: J. Vaillancourt Corp. Ltée, 7 Duvernay, Verchères, Québec.

Did you know...

Graduates of the Moose Jaw Union (General) Hospital School of Nursing are invited to a reunion to be held June 29-July 2, 1979. Contact: Mrs. G. Wilson, 4th Ave., no.1210, N.W., Moose Jaw, Sask.,



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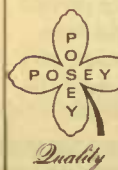
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Enemas Made Easy

Ready-to-use disposable enemas are very popular now, for many valid reasons. But for those patients with enlarged hemorrhoids or lax sphincters, we have found that the nozzle does not extend far enough into the rectum. We have also found however, that regular rectal tubing will fit onto the nozzle of the disposable container, making the enema very easy to administer.

—E. Rodgers, R.N., Winnipeg, Manitoba.

Emergency Eyewash

We find the following treatment helpful for a patient who comes in to emergency having splashed chemicals or an irritant like sawdust into his eyes: Have the patient lie on the side of the affected eye with a kidney basin beside his face. Connect intravenous normal saline to IV tubing, regulate the drip and irrigate the patient's eye. This is an effective treatment in the absence of an eyewash station.

—June Brayshaw, head nurse, Emergency Department, Mattawa General Hospital.

Teaching patients to rest

How can you teach your patients the art of relaxation? For the past five years, I've been teaching techniques of relaxation training (stress management) to individual patients and groups in hospital and community settings. Because practice is necessary in order to learn the techniques well, I've developed a 60 minute audio cassette tape which gives all the information necessary for

follow-up sessions. Patients use the tape to practice, to relieve pain and insomnia, to rest, and to develop feelings of well being and calmness.

Side One contains a 25 minute script which gives instructions for both breathing and progressive muscle relaxation exercises. The patient is asked to imagine that he is at a warm sunny beach. The voice of the reader is accompanied by soft guitar music.

Side Two first overviews the technique for autogenic training. The patient is helped to make mental contact with certain body parts by passively concentrating on the repetition of phrases such as "My arm is heavy" or "My legs are heavy and warm". Side Two also contains another beach scene which is designed as a pleasant, relaxing fantasy experience.

Patients are able to evaluate the usefulness of each relaxation technique using a 10 item questionnaire which measures somatic and cognitive states before and after practice.

The tape has been very well received. It is used by many well people in their homes and by patients and staff in a number of acute and chronic hospitals in British Columbia.

—Ada Butler, assistant professor, University of British Columbia, Vancouver, B.C.

Economical Breast Pads

When I taught prenatal classes or postpartum mothers, I suggested that they use disposable diapers, cut into the right size, as breast pads. The plastic covering can be removed to prevent sore nipples, or it can be left on for an evening out, to avoid soiling or embarrassment.

I also told my classes that sudden leakage, usually preceded by a tingling sensation in the breasts, may be stopped by pressing the palms of the hands against the nipples.

The mothers that I taught were always grateful for these suggestions.

—M.K. Hardy, R.N., Burlington, Ontario.

Books

Twenty-five years a-growing by Henrietta Jane Alderson, McMaster University School of Nursing, Hamilton, Ontario, 1976.
Approximate price: \$8.25

Anyone who has been involved with a university school of nursing for a few years, either as a student, faculty member or administrator, might feel that *Twenty-five years a-growing* is her own story.

Many Ontario university faculty members, in particular those of the newer universities, will recall how eager they were to learn from fellow university faculties about issues related to curriculum, teaching and administration in university schools. Although there have been a few such conferences (organized initially at the initiative of the Registered Nurses Association of Ontario and then by the Ontario Region of Canadian Associations of University Schools of Nursing) several members returned from them with a feeling of need, need for further sharing of the pains and pleasures of life in a university school. *Twenty-five years a-growing* is worth a million conferences of true sharing — McMaster has opened its doors through Alderson's pen.

The author has chosen an excellent method for writing a history: she has filled the book almost completely with quotes that are both humorous and most educational. The material is organized chronologically — starting with the roots of McMaster University itself, and following with the early budding and blooming of higher education in nursing within and without the university community.

The staunch beliefs and the determination of the pioneer nurse-educator to get started on the right footing, the tolerant understanding and steady pacing of the cautious traditional nurse administrator, as well as the dynamism and 'get-go' tempo of those of the seventies are all vividly painted throughout the pages. It is enlightening to note the vicious circle of approaches to curriculum construction — the first 'core' concept based on fundamentals of nursing, then the progressive changes based on varying theories such as 'basic needs', 'problem-solving', 'adaptation', 'systems', and a return to 'core' concepts.

McMaster University School of Nursing has not only kept up with the trends and needs of society, but has perhaps developed ahead of the times. The environment of the health science complex and the influences of personalities such as John Evans, Dorothy Kergin, and Fraser Mustard may also reveal socio-cultural, economic and political forces that affect the shaping of a health care delivery system and the education of health care personnel.

To many a reader around the world, this book will provide joy, confidence, and inspiration — also a warning to be sure to save all those old files of precious correspondence.

—Reviewed by Anna Gupta, professor,
University of Windsor, School of
Nursing, Windsor, Ontario.

Nursing standards and nursing process edited by Marion E. Nicholls and Virginia G. Wessels, Wakefield, Massachusetts, Contemporary Publishing Inc. 1977.
Approximate price: \$7.95

The authors of this text address themselves to senior nursing students in a baccalaureate program. While the book is in fact introductory, it is written in a concise and coherent fashion that clarifies the issues addressed. I feel that the book would be valuable in inservice and continuing education programs, in refresher courses for nurses returning to practice, in post-R.N. baccalaureate programs, and as a resource for practicing nurses who are beginning their involvement with standard setting and quality assurance.

The book is an anthology: it includes classic articles from the literature as well as original articles by the editors. It is divided into four units.

The first unit introduces the terminology and concepts necessary for discussion of nursing standards and quality assurance programs. The second unit considers the development of standards at the practice level. The actual process of standard setting in direct nursing care is the focus of the third unit. In the fourth unit, a series of

case studies with discussion of standards and quality assurance programs provide reality-based illustrations to balance the philosophical and theoretical presentations of the first three units.

The reader must be alert to the fact that a number of issues addressed — for example, Chapter 4 "Professional Standards Review Organization (PSROs)" — are of prime concern to the American Health care system and are relevant to Canadian nurses only to the extent that the trend may extend to Canadian health care legislation of the future.

—Reviewed by Kathryn J. Hannah, R.N.,
M.S.N., Assistant Professor, Faculty of
Nursing, University of Calgary,
Calgary, Alberta.

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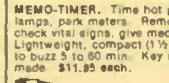
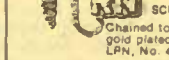
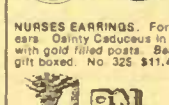
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SOLID METAL ... Extremely strong and durable but lightweight. Letters deeply engraved for absolute permanence and filled with your choice of lacquer colour. Corners and edges smoothly rounded. Satin smooth finish.	<input type="checkbox"/> Gold <input type="checkbox"/> Silver	<input type="checkbox"/> Black <input type="checkbox"/> Blue <input type="checkbox"/> Red <input type="checkbox"/> Green	1 line letters <input type="checkbox"/> \$3.99 2 line letters <input type="checkbox"/> \$4.79	<input type="checkbox"/> \$3.99 <input type="checkbox"/> \$4.79	<input type="checkbox"/> \$3.99 <input type="checkbox"/> \$4.79	<input type="checkbox"/> \$7.98 <input type="checkbox"/> \$9.58					

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Classified Advertisements

British Columbia

Experienced Graduate Nurses required for small hospital located N.E. Vancouver Island. Maternity experience preferred. Personnel policies according to RNABC contract. Residence accommodation available. Apply in writing to: Director of Nursing, St. George's Hospital, Alert Bay, British Columbia, V0N 1A0.

General Duty Nurses for modern 41-bed accredited hospital located on the Alaska Highway. Salary and personnel policies in accordance with the RNABC. Temporary accommodation available in residence. Apply: Director of Nursing, Fort Nelson General Hospital, P.O. Box 60, Fort Nelson, British Columbia, V0C 1R0.

General Duty Registered or Graduate Nurses — needed for 25-bed acute care hospital in North Central B.C. Salary and working conditions according to the RNABC Contract. Apply: Director, Stuart Lake Hospital, Fort St. James, British Columbia, V0J 1P0 or call collect (604) 996-8201/996-7305.

Operating Room Head Nurse — Must be RNABC registered. Must have experience in all O.R. procedures. Salary—According to the RNABC agreement. Please apply in writing to: Mrs. M. Asling, Director of Nursing, Fort St. John General Hospital, Fort St. John, British Columbia, V1J 1Y3.

General Duty Nurse for modern 35-bed hospital located in southern B.C.'s Boundary Area with excellent recreation facilities. Salary and personnel policies in accordance with RNABC. Comfortable Nurse's home. Apply: Director of Nursing, Boundary Hospital, Grand Forks, British Columbia, V0H 1H0.

General Duty Registered Nurses — required for 130-bed accredited hospital. Previous experience desirable. Staff residence available. Salary as per RNABC contract with northern allowance. For further information please contact: Director of Nursing, Kitimat General Hospital, 899 Lahakas Boulevard North, Kitimat, British Columbia, V8C 1E7.

Experienced Nurses (B.C. Registered) required for expansion to 463 bed acute, teaching, regional referral hospital located in Fraser Valley, 20 minutes by freeway from Vancouver, and within easy access of various recreational facilities. Excellent orientation and continuing education programmes. Salary: \$1184.00-\$1399.00 per month (1977 rates). There is an immediate need in coronary care, intensive care, operating rooms and hemodialysis because of increased services. Other clinical areas include medicine, surgery, obstetrics, pediatrics, emergency and rehabilitation. Apply to: Personnel, Royal Columbian Hospital, New Westminster, British Columbia, V3L 3W7.

Registered Nurses — Required immediately for a 340-bed accredited hospital in the central interior of B.C. Registered Nurses interested in nursing positions at the Prince George Regional Hospital are invited to make inquiries to: Director of Personnel Services, Prince George Regional Hospital, 2000—15th Avenue, Prince George, British Columbia V2M 1S2.

British Columbia

Experienced Nurses (eligible for B.C. Registration) required for full-time positions in a new 300-bed Extended Care Hospital located just thirty minutes from downtown Vancouver. Salary and benefits according to RNABC contract. Applicants may telephone 525-0911 to arrange for an interview, or write giving full particulars to: Personnel Director, Queen's Park Hospital, 315 McBride Blvd., New Westminster, British Columbia, V3L 5E8.

Experienced General Duty Nurse — required for 45-bed acute care hospital in central B.C. Maternity or paediatric experience preferred. Accommodation available in residence. Apply to: Director of Nursing, St. John Hospital, Vanderhoof, British Columbia, V0J 3A0.

Faculty — New Position (1) in 2-year post-basic baccalaureate program in Victoria, B.C., Canada. Generalist in focus, clinical experience is provided in gerontology in community and supportive extended care units, and in community nursing. Highly-qualified and motivated students in a dynamic academic environment stimulate teaching creativity which, with research, is strongly endorsed. Master's degree, teaching and recent clinical experience in gerontology/med.-surg./rehabilitation preferred. Salaries and fringe benefits competitive; an equal opportunity employer for qualified persons. Appointment effective July 1, 1979. Contact: Dr. Isabel MacRae, Director, School of Nursing, University of Victoria, P.O. Box 1700, Victoria, B.C., Canada, V8W 2Y2. Telephone (Area Code 604) 477-6911 - Local 4814.

Manitoba

Nurse Practitioner — required for an innovative community sponsored Health Center in Winnipeg's core area. Will work on a team with a family physician and health workers to provide medical, social and out-reach services. Salary to \$16,700. Excellent fringe benefits. Qualifications: must be a Registered Nurse with post-graduate education or certificate in family nurse practice and preference given to those with at least one year's experience. Please send resume by December 20 to: Personnel Committee, Health Action Center, 425 Elgin Avenue, Winnipeg, Manitoba R3A 1P2.

Registered Nurses Louisiana two locations New Orleans & Lake Charles

New active care accredited hospitals have a requirement for four Canadian R.N.'s experienced in critical care. As the hospitals are only interested in persons becoming registered aliens of the USA, these positions would be of interest to the married RN whose spouse could not obtain a work permit under the regulations covering the H-1 temporary permit. Candidates must, under Louisiana licensing, have written RN's in Canada and received marks of 350 in all five disciplines to obtain license by reciprocity. Apply in confidence to W. P. Dow & Associates Ltd., (a Canadian company) Suite 309, 365 Evans Avenue, Toronto, Ontario M8Z 1K2 (416) 259-6052

United States

St. Joseph's Hospital of Tucson, Arizona — has several openings for experienced R.N.'s. Progressive 325-bed acute care community hospital located in Southern Arizona's superb climate. Close to mountain skiing and the beaches of Mexico. Salary and benefit package are excellent including a tuition reimbursement program which can be utilized at the University of Arizona which offers BSN and MSN Degrees. Write: Human Resources Department, St. Joseph's Hospital, P.O. Box 12069, Tucson, Arizona, 85732. An Equal Opportunity Employer.

RNs — A rewarding career awaits you in Las Vegas. Join Valley Hospital and realize your nursing potential while enjoying the unique lifestyle of sunny Las Vegas. Valley Hospital is a progressive, fully-accredited 277-bed facility noted for providing high quality personalized medical care. We offer an excellent salary and benefit package. For more information, write or call collect: Kalene Ryan, Nurse Recruiter, CN-12, Valley Hospital, 620 Shadow Lane, Las Vegas, Nevada, 89106, (702) 385-3011.

RN's — Boise, Idaho — How would you like a rewarding career in an environment which offers you immediate access to uncongested recreation areas with rivers, lakes and mountains? Do you enjoy tennis, golf, racketball, camping, hiking, skiing and horseback riding? Sound exciting? It is. And there are many opportunities for satisfying work at one of Idaho's largest and most progressive medical complexes. St. Alphonsus, located in Boise, is a 229-bed facility offering you positions in orthopedics, ophthalmology, dialysis, mental health, neurosurgery and trauma medicine. Excellent salary, generous benefits and job security. Starting salary adjusted for experience; benefits include travel assistance, shift rotation, and free parking. Write or call collect: Employment Supervisor, Personnel Office, St. Alphonsus Hospital, 1055 North Curtis Road, Boise, Idaho 83704, (208) 376-3613. EOE.

Nursing Opportunity — Mississippi Baptist Medical Center, a major 600-bed hospital, has immediate positions available for experienced RNs and recent nursing school graduates in a variety of specialties and medical/surgical areas. Competitive salaries, liberal benefits. Visa, licensure and relocation assistance provided. Located in Mississippi's capital city of Jackson (population 300,000), MBMC is the state's largest and most modern privately operated hospital. For further information write: Mrs. Johnnye Weber, Nurse Recruiter, 1225 North State Street, Jackson, Mississippi 39201; or call collect 601/968-5135.

Nurses — RNs — Immediate Openings in California-Florida-Texas-Mississippi — if you are experienced or a recent Graduate Nurse we can offer you positions with excellent salaries of up to \$1300 per month plus all benefits. Not only are there no fees to you whatsoever for placing you, but we also provide complete Visa and Licensure assistance at also no cost to you. Write immediately for our application even if there are other areas of the U.S. that you are interested in. We will call you upon receipt of your application in order to arrange for hospital interviews. You can call us collect if you are an RN who is licensed by examination in Canada or a recent graduate from any Canadian School of Nursing. Windsor Nurse Placement Service, P.O. Box 1133, Great Neck, New York 11023. (516-487-2818).

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Miscellaneous

Africa — Overland Expeditions. London/Nairobi 13 wks. London/Johannesburg 16 wks. Kenya Safaris — 2 and 3 wk. itineraries. **Europe** — Camping and hotel tours from 16 days to 9 wks. duration. For brochures contact: Hemisphere Tours, 562 Eglinton Ave. E., Toronto, Ontario, M4P 1B9.



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An active 250 bed Regional Hospital requires a registered nurse for:

Supervisor — Operating and Recovery Rooms with a baccalaureate or diploma in nursing administration, post-graduate course in operating room techniques, a minimum of two years operating room experience, and demonstrated management ability.

Please send complete resume to:

Director of Personnel
Kentville Hospital Association
186 Park Street
Kentville, N.S.
B4N 1M7

Foothills Hospital, Calgary, Alberta

Advanced Neurological- Neurosurgical Nursing for Graduate Nurses

A five month clinical and academic program offered by The Department of Nursing Service and The Division of Neurosurgery (Department of Surgery)

Beginning: March, September

Limited to 8 participants
Applications now being accepted

For further information, please write to:
Co-ordinator of In-service Education
Foothills Hospital
1403 29 St. N.W. Calgary, Alberta
T2N 2T9

United States

Come to Texas — Baptist Hospital of Southeast Texas is a 400-bed growth oriented organization looking for a few good R.N.'s. We feel that we can offer you the challenge and opportunity to develop and continue your professional growth. We are located in Beaumont, a city of 150,000 with a small town atmosphere but the convenience of the large city. We're 30 minutes from the Gulf of Mexico and surrounded by beautiful trees and inland lakes. Baptist Hospital has a progress salary plan plus a liberal fringe package. We will provide your immigration paperwork cost plus airfare to relocate. For additional information, contact: Personnel Administration, Baptist Hospital of Southeast Texas, Inc., P.O. Drawer 1591, Beaumont, Texas 77704. An affirmative action employer.

United States

Primary Children's Medical Center in Utah has A Place for You, RN's — interested in new born intensive care—We want you! We've opened our new 22-bed intensive care center and have positions available. RN's for Medical, Surgical, Semi-Intensive Care Units and Nursery. Primary Children's Medical is located in a beautiful residential section of Salt Lake City, only minutes from recreational and skiing areas in the Rockies. Excellent benefits package include tuition reimbursement. Temporary housing can also be arranged. For personal interview write or call collect now: Beverlee Aaron, RN, Nurse Recruiter, 320 12th Ave., Salt Lake City, Utah 84103. Phone 1-801-328-9061, Ext. 351. E.O.E. M/F.

Nurses: Try Canada's Northland This Summer

Infirmières: Découvrez les Terres Septentrionales du Canada cet été.

Join the team providing health care to the residents of the Northwest Territories. Medical Services, Northwest Territories Region will be offering a number of term positions for qualified and experienced nurses.

Positions are available at nursing stations, health centres and hospitals for the period, May through September.

Knowledge of the English language is essential.

For more information write to:
Personnel Administrator,
Medical Services,
Northwest Territories Region,
Health and Welfare Canada
14th Floor, Baker Centre,
10025 - 106 Street
Edmonton, Alberta T5J 1H2

NOTE: Permanent positions are also available.

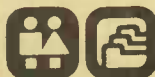
Joignez-vous à l'équipe médicale qui soigne les habitants des Territoires du Nord-Ouest. La direction des Services médicaux, région des Territoires du Nord-Ouest, offre des postes d'infirmières diplômées, pour une période déterminée.

Les postes offerts se trouvent dans des postes de soins infirmiers, des centres sanitaires ou des hôpitaux; la période de travail va de mai à septembre.

La connaissance de l'anglais est indispensable.

Pour de plus amples renseignements, prière d'écrire à l'adresse suivante:
L'administrateur du personnel, Services médicaux, Région des Territoires du Nord-Ouest, Santé et Bien-être social Canada, 14e étage, Centre Baker, 10025 - 106e Rue, Edmonton (Alberta) T5J 1H2

REMARQUE: Des postes permanents sont également offerts.



Applicant Inventory

Open to both men and women

Répertoire de candidatures

Appel de candidatures mixtes



Registered Nurses

Attention: If you are a registered nurse having taken the Canadian Nurses Association Testing Service or State Board Testing Pool examination, you are probably eligible for an Ohio license. Why not explore exciting career opportunities in Ohio? Positions are available throughout the State which offer diverse functions ranging from staff nursing, unit team member, educational training director, and director of nursing, all of which provide the opportunity for rapid advancement and professional growth. You will enjoy competitive starting salary, shift differential plus excellent fringe benefits.

For further information, please contact or send resume to:

The Ohio Department of Mental Health
and Mental Retardation
Recruitment Office — Suite 1160
30 East Broad Street
Columbus, Ohio 43215
(614) 466-2274

Dalhousie University School of Nursing

Nurse faculty members are required for the academic year 1979-80. Applicants, with a Doctoral or Masters degree, interested in teaching in the Baccalaureate Degree Programs (Basic and Post Basic) and/or in the Masters in Nursing Degree program are invited to apply. Previous experience of teaching and in clinical nursing will be an advantage.

Level of appointment and salary will be commensurate with qualifications and experience.

Applications with a Curriculum Vitae and three referees should be sent to:

Dr. Margaret Scott Wright
Professor and Director
School of Nursing
Dalhousie University
Halifax, Nova Scotia
B3H 4H7

Neo Natal Nurses

Come to Canada's Ocean Playground! The Izaak Walton Killam Hospital for Children, located in Halifax, Nova Scotia, has interesting and challenging employment opportunities for nurses in our Neo Natal Unit.

All new employees will receive a full orientation program. Salary commensurate with qualifications and experience.

For further information contact:

Karen Lyle
Personnel Officer
IWK Hospital for Children
P. O. Box 3070
Halifax, Nova Scotia
B3J 3G9
Phone 902 - 424-3012

United States

Nursing Opportunities — Progressive 500-bed Medical Center in West Texas city of Abilene with population nearly 100,000 is looking for new graduates and experienced R.N.'s for positions in O.B., Pediatrics, Surgery, E.R., ICU, CCU, plus surgical and medical floors. Good competitive salary and generous benefits are provided. Contact: Personnel Office, Hendrick Medical Center, 19th and Hickory, Abilene, Texas, 79601.

United States

Check out Intermountain Health Care, Inc.—Select the nursing environment which best suits you. We have 19 community hospitals of varying size and 3 specialty referral centers. The potential for advancement and continuing education is excellent! Enjoy your free time skiing or hiking in pine and aspen forests or visiting a variety of scenic attractions. Contact: SallyJo Lee, Recruitment Manager, Intermountain Health Care, Inc., 36 So. State, Suite 2200-L, Salt Lake City, UT 84111, (801) 533-8282.

Switzerland

Winterthur Canton (725 bed) hospital near Zürich needs Operating Room Nurses for the surgery clinic. Required for immediate or future openings. We offer pleasant working conditions, equitable hours of work and leisure. Salary and benefits in accordance with the regulations of the Canton of Zürich. Five-day week, accommodation available, cafeteria. Apply in writing to: Sekretariat Pflegedienst, Kantonsspital Winterthur, CH-8401 Winterthur, Switzerland.

Nursing Opportunities in Vancouver Vancouver General Hospital

If you are a Registered Nurse in search of a change and a challenge — look into nursing opportunities at Vancouver General Hospital, B.C.'s major medical centre on Canada's unconventional West Coast. Staffing expansion has resulted in many new nursing positions at all levels, including:

General Duty (\$1231-1455.00 per mo.)

Nurse Clinician

Nurse Educator

Supervisor

Recent graduates and experienced professionals alike will find a wide variety of positions available which could provide the opportunity you've been looking for.

For those with an interest in specialization, challenges await in many areas such as:

Neonatology Nursing **Intensive Care**
(General & Neurosurgical)

Inservice Education **Cardio-Thoracic Surgery**

Coronary Care Unit **Burn Unit**

Hyperalimentation Program **Paediatrics**

Renal Dialysis & Transplantation

If you are a Nurse considering a move please submit resume to:

Mrs. J. MacPhail
Employee Relations
Vancouver General Hospital
855 West 12th Avenue
Vancouver, B.C. V5Z 1M9

Director of Nursing Service

required for
McKellar General Hospital
rated bed capacity 389

Facilities include regional Renal Dialysis and Neurosurgical Units, a 24 bed Psychiatric Unit and general active treatment medical and surgical services.

The successful applicant will be required to have extensive experience in the administration of a complete Nursing program and will possess at least a B.Sc.N. degree.

A liberal range of fringe benefits includes: 4 weeks annual vacation, 11 paid holidays per year, accumulative sick leave benefits, employer paid O.H.I.P. premiums.

Position open on retirement of present incumbent.

Address all enquiries in writing, together with complete resume to:

Douglas M. McNabb
Administrator
McKellar General Hospital
Thunder Bay
Ontario
P7E 1P6

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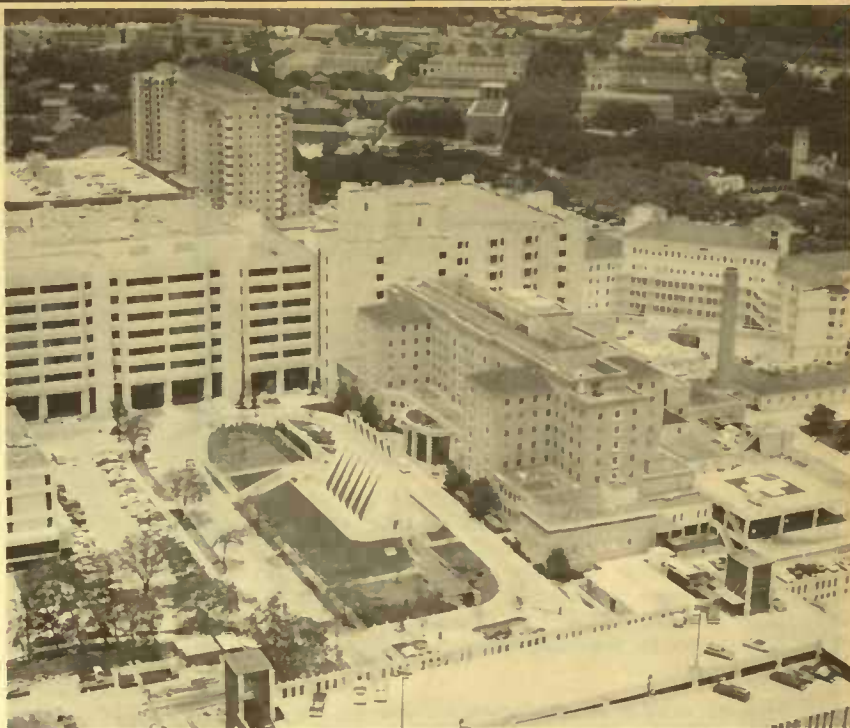
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Att: Nurse Recruiter
1203 Ross Sterling Avenue
Texas Medical Center
Houston, Texas 77030

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Address _____
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State _____ Zip _____
Phone _____
Specific Area of Interest _____
(Circle) RN LVN Student Nurse

THE UNIVERSITY OF CALGARY

DEAN OF THE FACULTY
OF NURSING

Applications and nominations are invited for the position of Dean of the Faculty of Nursing, effective July 1, 1979.

The Faculty of Nursing was established in 1969 and consists of 253 undergraduate students and 20 full-time faculty members. It offers a four-year basic and a two-year post-R.N. program leading to a Bachelor of Nursing degree. A graduate program leading to a Master's degree in nursing is also being planned for the near future.

As the senior administrative officer of the Faculty, the Dean is expected to offer dynamic leadership in the continual development of teaching and research programs. Candidates should have a distinguished academic record, and provide evidence of substantial experience in university teaching, scholarship and administration.

An up-to-date curriculum vitae and the names and addresses of three referees should be sent to:

Miss J. M. Nicholson,
Assistant to the President,
The University of Calgary,
2920 - 24 Avenue N.W.,
Calgary, Alberta T2N 1N4



The Red Deer Regional Hospital Centre requires the following staff for their rapidly expanding complex which is located in Central Alberta with close proximity to major recreational and shopping facilities.

ASSISTANT DIRECTOR
OF NURSING
EXTENDED CARE**Position:**

Responsible to the Director of Nursing for the organization and administration of our 100 bed Auxiliary Hospital as well as three Nursing Homes.

Person: The applicant should have 3 to 5 years experience in Nursing with a minimum of 2 years managerial experience. A Bachelor of Science Degree would be an asset. The applicant should have a keen interest in Rehabilitation Medicine and Extended Care

TEACHING ASSISTANT
HEAD NURSE
MEDICAL UNIT

We require the services of an experienced Registered Nurse with an interest in teaching and staff development on a Medical Unit. A Baccalaureate Degree would be desirable.

The above positions are effective immediately.

Interested applicants please apply to:

Personnel Department
Red Deer Regional Hospital Centre
3942 50A Avenue
Red Deer, Alberta
T4N 4E7

St. Peter's Hospital

Hamilton, Ontario

requires

Assistant Administrator Patient Care
(Director of Nursing)

St. Peter's Hospital, a 284-bed accredited geriatric, chronic care hospital, also operating a unique Day Therapy Centre, requires an Assistant Administrator Patient Care (Director of Nursing) to replace incumbent retiring in February, 1979.

The Assistant Administrator Patient Care is the key member of the management team in establishing and maintaining St. Peter's philosophy throughout the Centre.

The Assistant Administrator Patient Care is responsible for developing policies within the general aims of the Centre to ensure effective patient care management including admission, pre-admission, evaluation, and discharge planning, as necessary.

St. Peter's Centre has been fully rebuilt and is developing expanded programmes in rehabilitation, long term care and day therapy for the geriatric community.

The problem oriented approach followed by a multi-disciplinary team in which nursing assumes a major role.

Qualifications:

Registered Nurses with a Bachelor of Science in Nursing degree or other health related degree, or a Registered Nurse with identifiable equivalent qualification.

Several years experience which include some time spent in a managerial role is a requirement.

A background in geriatrics and/or educational programmes is an asset.

1978 Salary Range is \$22,900 to \$27,900 per annum.

Enquiries should be directed, along with full information, by December 15th, 1978, to:

Chairman, Search Committee
St. Peter's Centre
88 Maplewood Avenue
Hamilton, Ontario
L8M 1W9

Administrative Co-Ordinator #1

Research and Management
Information

The Holy Cross Hospital, a 520 bed active treatment centre, is at present recruiting for the position of Administrative Co-ordinator.

The Position: primarily provides management information on and the evaluation of activities related to nursing and the delivery of patient care. In addition to assessing existing practices the co-ordinator is also responsible for providing innovative and creative plans and suggestions.

The Candidate: must be able to communicate effectively with all levels of staff. Good management skills, research abilities and a broad knowledge of health concepts necessary.

Applicants should be registered nurses with a baccalaureate in Nursing or a related field. Preference will be given to a Masters degree. Research preparation essential. A minimum of two years nursing in an active treatment setting necessary.

Please send a complete resume stating date available to:

Director of Personnel
Personnel Department
Metro-Calgary and Rural General Hospital
District No. 93
940 - 8 Ave., S.W.
Calgary, Alberta
T2P-1H8



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78-RPC-22-5	Nursing Team Leader	(15 vacancies)
78-RPC-22-6	Staff Nurse	(36 vacancies)

Solicitor General

Canadian Penitentiary Service, Saskatoon, Saskatchewan

The Regional Psychiatric Centre, a modern, forensic 110-bed facility, has immediate openings within the Nursing Department.

The Centre is a new, acute-care facility which will open approximately January 1979 in Saskatoon. An intensive orientation to this facility is planned as well as an active continuing in-service education program.

Qualifications

Applicants must possess eligibility for registration as a registered nurse in a province or territory of Canada. Knowledge of English is essential.

For additional information, please contact the Personnel Office at (306) 373-5130, Ext. 220 in Saskatoon.

How to Apply

Send your application form and/or résumé to:

R. Norrie

Public Service Commission of Canada

500 — 286 Smith Street

Winnipeg, Manitoba R3C 0K6

Please quote the applicable reference number at all times.

NURSES

Salary up to \$15,783 (under review)

Reference No:

78-MSB-MAN-22

78-MSB-SASK-22

Health and Welfare Canada

Medical Services Branch

Manitoba and Saskatchewan Regions

Various locations — Northern Manitoba and Saskatchewan

Nurses are urgently required for treatment and public health care stations for hospitals in Northern Manitoba and Saskatchewan.

Qualifications

Applicants must possess eligibility for registration as a Nurse in a province or territory of Canada. Nurses possessing a Bachelor of Science degree in Nursing or a certificate in public health nursing will be given preference, however, experienced registered nurses will also be considered. Knowledge of English is essential.

Further information may be obtained by calling collect to Mr. A. Wozniak (204) 949-4183 in Winnipeg or Mr. G. Warrenchuk at (306) 569-5418 in Regina.

How to Apply

Send your application form and/or résumé to:

R. Norrie

Public Service Commission of Canada

500 — 286 Smith Street

Winnipeg, Manitoba R3C 0K6

Please quote the applicable reference number at all times.

MANIT^{BA}

CIVIL SERVICE COMMISSION

This position is open to both men and women.

Apply in writing referring to Competition Number CN 434 immediately.

Director, Staff Development Programs

The Department of Health & Social Development, Mental Health Services, Brandon Mental Health Centre, requires a person to be responsible for Staff Development and related programs reporting to the Senior Nursing Administrative Officer. Assist in identifying and assessing staff educational needs, help design programs, and evaluate their effectiveness.

Baccalaureate in Nursing, Psychiatric Nursing experience. Specialization in Nursing and/or Adult Education desirable. Valid Manitoba licence required.

Salary Range: \$17,758 - \$21,688 per annum

Civil Service Commission
340 - 9th Street
Brandon, Manitoba R7A 6C2

Nurses

The Department of Northern Saskatchewan, Health Services Branch requires several well qualified nurses to provide a comprehensive community health nursing program and, in some cases, primary nursing diagnosis and emergency treatment.

Candidates should have considerable experience in general nursing and preferably completion of a university degree in nursing and be eligible for registration in the Province of Saskatchewan.

The purpose of this competition is to establish an eligible list from which present and future vacancies may be filled. For further information please contact Alice Mills, Nursing Supervisor, Department of Northern Saskatchewan, Box 5000, La Ronge, Saskatchewan.

Salary:

\$16,080 — \$19,464 (Nurse 4)

\$16,704 — \$20,268 (with B.Sc.N.)

Salaries are adjusted in accordance with job responsibilities. A northern allowance of \$47.50 to \$145.00 per month, depending on location is also in effect.

Competition: 604114-8-780 Closing: As soon as possible.

Forward your application forms and/or resumes to the Public Service Commission, 1820 Albert Street, Regina, quoting position, department and competition number.

OPPORTUNITY

Alberta

DIRECTOR OF NURSING

Rosehaven, a residential facility for approximately 300 geriatric patients with psycho-social handicaps, has a challenging senior position for a qualified person interested in nursing administration. The successful candidate will be responsible for providing dynamic innovative leadership of the Nursing Department in the Centre. Full opportunity will be available to maintain, modify, or expand existing programs and to implement rehabilitation and activation concepts. The individual will also be responsible for the supervision of the Recreational and Occupational Therapy Department, Social Services, Pharmacy and In-Service Education. Rosehaven is located approximately 60 miles southeast of Edmonton in the modern progressive Central Alberta city of Camrose, population 10,000. Qualifications: The successful candidate will be a graduate of an approved School of Nursing, (preferably a B.Sc. in Nursing Administration) eligible for nursing registration in Alberta, and have considerable professional nursing experience in which leadership and other administrative skills have been demonstrated.

Salary up to \$24,876 dependent on academic qualifications and experience.

Competition #M341-28

This competition will remain open until a suitable candidate has been selected.

Apply To:

Alberta Government Employment Office
5th Floor, Melton Building
10310 Jasper Avenue
Edmonton, Alberta
T5J 2W4

OPPORTUNITY

Alberta

ASSOCIATE DIRECTOR OF NURSING SERVICES

Alberta Hospital, located 4 km. N.E. of Edmonton, requires an individual for administration, assuming a leadership role in assessment, planning, organization, directing, evaluating and making revisions to improve patient care, and promoting staff development and research.

NOTE: Transportation is available from Edmonton.

Qualifications: Graduation from an approved School of Nursing, eligible for registration in Alberta. Extensive, progressive nursing experience with demonstrated leadership and other administrative skills; Psychiatric nursing background an asset.

Salary \$18,948 - \$24,876

Competition #M341-35

This competition will remain open until a suitable candidate has been selected.

Application forms may be obtained from and should be returned to: Personnel Director, Alberta Hospital, Edmonton, Box 307, Edmonton Alberta. T5J 2J7 or phone (403) 973-2212.

Pampers gives you both a break

Keeps him drier

Instead of holding moisture, Pampers hydrophobic top sheet allows it to pass through and get "trapped" in the absorbent wadding underneath. The inner sheet stays drier, and baby's bottom stays drier than it would in cloth diapers.



Saves you time

Pampers construction helps prevent moisture from soaking through and soiling linens. As a result of this superior containment, shirts, sheets, blankets and bed pads don't have to be changed as often as they would with conventional cloth diapers. And when less time is spent changing linens, those who take care of babies have more time to spend on other tasks.

If

butter really is the culprit in
Canadians' over-consumption of fat

how come

it accounts for less than 12%
of their dietary fat intake?



Canadians who are serious about
reducing their fat consumption should
look beyond the butter dish. Some major
fat-contributing foods are meat, poultry,
fish, eggs (39%); cereal products (15%);
fats and oils (19%)*.

*Includes margarine, butter, salad oil, cooking oil.

Source: Nutrition Canada — "Food Consumption Pattern
Report 1977", Health & Welfare Canada,
Table 7.3, Males 40-64 years.

**When you look at the facts
you can see the good in butter.**

Canadian Dairy Foods Service Bureau

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